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SECURITIES AND EXCHANGE COMMISSION

WASHINGTON, D.C. 20549

FORM S-1
REGISTRATION STATEMENT

UNDER
THE SECURITIES ACT OF 1933

Molina Healthcare, Inc.

(Exact name of registrant as specified in its charter)

Delaware	**6324**	**13-4204326**
(State or other jurisdiction of incorporation or organization)	**(Primary Standard Industrial Classification Code Number)**	**(I.R.S. Employer Identification Number)**

One Golden Shore Drive
Long Beach, CA 90802
(562) 435-3666
(Address, including zip code, and telephone number including area code, of registrant's principal executive offices)

J. Mario Molina, M.D.
President and Chief Executive Officer
One Golden Shore Drive
Long Beach, CA 90802
(562) 435-3666
(Name, address, including zip code, and telephone number including area code, of agent for service)

Copies to:

Douglas M. Mancino, Esq.
Mark J. Mihanovic, Esq.
McDermott, Will & Emery
2049 Century Park East, Suite 3400
Los Angeles, CA 90067
(310) 277-4110

William J. Grant, Jr., Esq.
Willkie Farr & Gallagher
787 Seventh Avenue
New York, New York 10019
(212) 728-8000

Approximate date of commencement of proposed sale to the public: As soon as practicable after the effective date of this Registration Statement.

If any of the securities being registered on this form is to be offered on a delayed or continuous basis pursuant to Rule 415 under the Securities Act of 1933 check the following box. ☐

If this Form is filed to register additional securities for an offering pursuant to Rule 462(b) under the Securities Act, please check the following box and list the Securities Act registration statement number of the earlier effective registration statement for the same offering. ☐

If this Form is a post-effective amendment filed pursuant to Rule 462(c) under the Securities Act, check the following box and list the Securities Act registration statement number of the earlier effective registration statement for the same offering. ☐

If this Form is a post-effective amendment filed pursuant to Rule 462(d) under the Securities Act, check the following box and list the Securities Act registration statement number of the earlier effective registration statement for the same offering. ☐

If delivery of the prospectus is expected to be made pursuant to Rule 434 under the Securities Act, please check the following box. ☐

CALCULATION OF REGISTRATION FEE

Title of Each Class of Securities to be Registered	Proposed Maximum Aggregate Offering Price(1)	Amount of Registration Fee
Common Stock, par value $0.001	$115,000,000	$10,580

(1) Estimated solely for the purpose of calculating the registration fee pursuant to rule 457(a) of the Securities Act of 1933.

The Registrant hereby amends this Registration Statement on such date or dates as may be necessary to delay its effective date until the Registrant shall file a further amendment which specifically states that this Registration Statement shall thereafter become effective in accordance with Section 8(a) of the Securities Act of 1933 or until this Registration Statement shall become effective on such date as the Securities and Exchange Commission, acting pursuant to Section 8(a), may determine.

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The information contained in this prospectus is not complete and may be changed without notice. These securities may not be sold until the registration statement filed with the Securities and Exchange Commission is effective. This prospectus is not an offer to sell these securities, and it is not soliciting an offer to buy these securities, in any state where the offer or sale of these securities is not permitted.

PROSPECTUS (Not Complete)
Issued , 2003

Shares

Common Stock

Molina Healthcare, Inc. is offering shares of common stock in a firmly underwritten offering.

This is Molina Healthcare, Inc.'s initial public offering, and no public market currently exists for its shares. Molina Healthcare, Inc. anticipates that the initial public offering price for its shares will be between $ and $ per share. After the offering, the market price for Molina Healthcare, Inc.'s shares may be outside of this range.

Molina Healthcare, Inc. has applied to list its common stock on the New York Stock Exchange under the symbol "MOH."

Investing in the common stock involves a high degree of risk.
See " Risk Factors" beginning on page 6.

Neither the Securities and Exchange Commission nor any state securities commission has approved or disapproved of these securities or determined if this prospectus is truthful or complete. Any representation to the contrary is a criminal offense.

	Per Share	Total
Offering Price	$	$
Discounts and Commissions to Underwriters	$	$
Offering Proceeds to Company	$	$

The underwriters also may purchase from Molina Healthcare, Inc. up to an additional shares of common stock at the public offering price less the underwriting discounts and commissions, to cover any over-allotments. The underwriters can exercise this right at any time within 30 days after the offering. The underwriters expect to deliver the shares of common stock to investors on , 2003.

Joint Book-Running Managers

Banc of America Securities LLC **CIBC World Markets**

SG Cowen

, 2003

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[INSIDE COVER: COVER ART]

[Artwork in twelve colors depicting a woman and child approaching a “welcome” sign over a path which winds through a hillside. Caption below reads: “Healthy families begin with Molina Healthcare.” Below caption is Molina Healthcare’s logo.]

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You should rely only on the information contained in this prospectus. We have not authorized anyone to provide you with different information. We are not making an offer to sell these securities in any jurisdiction where the offer or sale is not permitted. You should assume that the information appearing in this prospectus is accurate as of the date on the front cover of this prospectus only. Our business, financial condition, results of operations and prospects may have changed since that date.

PROSPECTUS SUMMARY

This summary highlights information contained elsewhere in this prospectus. Because it is a summary, it does not contain all of the information that you should consider before investing in the shares. You should read the entire prospectus carefully before buying shares in this offering.

Our Business

We are a rapidly growing, 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 by C. David Molina, M.D. as a provider organization serving the Medicaid population through a network of primary care clinics in California. In 1994, we received our health maintenance organization, or HMO, license and began operating as a health plan. Over the past several years, we have taken advantage of attractive expansion opportunities and now operate health plans in California, Washington, Michigan and Utah. Our annual revenue has grown from $135.9 million in 1998 to $503.9 million in 2001, while our net income grew from $2.6 million to $30.1 million over the same period. Our net income has grown at a greater rate than our revenues due to our effective medical management programs and ability to leverage fixed costs. As of September 30, 2002, we had approximately 478,000 members.

From our inception, we have designed our company to work with government agencies to serve low-income populations. Low-income families and individuals have distinct social and medical needs and are characterized by their cultural, ethnic and linguistic diversity. Our success has been driven by our expertise in working with government programs, experience with low-income members, 22 years of owning and operating primary care clinics, our cultural and linguistic expertise and our focus on operational and administrative efficiency. We believe our proven ability to replicate our disciplined business model in new markets and our ability to customize provider contracts to local conditions position us well for continued growth and success.

Our Industry

Medicaid provides health care coverage to low-income families and individuals and is jointly funded by state and federal governments. Each state establishes its own eligibility standards, benefit packages, payment rates and program administration within federal guidelines. In 2001, Medicaid covered approximately 44.6 million individuals, with 51% of those being children, according to the Kaiser Commission on Medicaid and the Uninsured. The federal Centers for Medicare and Medicaid Services, or CMS, estimates the total health care expenditures for Medicaid and the State Children’s Health Insurance Program was $228.0 billion in 2001 and projects that total outlays will reach $372.9 billion in 2007.

Under traditional Medicaid programs, health care services are made available to low-income individuals in a largely uncoordinated manner. Beneficiaries typically receive minimal preventive care such as immunizations and have limited access to primary care physicians. 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 incentives to monitor utilization and control costs. In response, the federal government has expanded the ability of state Medicaid agencies to explore, and, in many cases, mandate the use of managed care for Medicaid beneficiaries. From 1996 to 2001, managed care enrollment among Medicaid beneficiaries increased from approximately 13.3 million to approximately 20.8 million, according to CMS. All states in which we operate have mandated Medicaid managed care programs in place.

Our Competitive Advantages

We have built a leading Medicaid managed care company by integrating those capabilities that we believe are essential to competing successfully in our industry. Our competitive advantages include:

Experience. We have significant expertise as a government contractor and a very strong track record of obtaining and renewing contracts. We have served Medicaid beneficiaries as a provider and a health plan for 22 years. In that time we have developed and forged strong relationships with the constituents whom we serve— members, providers and government agencies.

Administrative Efficiency. We maintain a disciplined focus on business processes and have centralized and standardized various functions and practices across our health plans. 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 in new and existing markets.

Proven Expansion Capability. We have successfully replicated our business model in new markets through the acquisition of health plans, the development of new operations and the transition of members from other plans. The establishment of our health plan in Utah reflected our ability to replicate our business model in new states, while the acquisitions in Michigan and Washington demonstrated our ability to acquire and successfully integrate existing operations.

Flexible Care Delivery Systems. Our systems for delivery of health care services are diverse and readily adaptable to different markets and changing conditions. We contract with providers that are best suited, based on proximity, culture and experience, to provide services to a low income population. In addition, we operate 21 primary care clinics in California. These clinics require low capital expenditures, minimal startup time and are profitable. Our clinics provide select 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. We have significant expertise in developing targeted health care programs for our culturally diverse members. We contract with a broad network of providers who have the capabilities to address the language and cultural needs of our members. We believe we are well-positioned to successfully serve this growing population.

Proven Medical Management. We believe our experience as a provider has helped us improve medical outcomes for our members and lower costs. 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 also designed and implemented disease management and health education programs that address the particular health care needs of a culturally diverse, low-income population.

Our Strategy

Our objective is to be the leading managed care organization serving low-income families and individuals. To achieve this objective, we intend to:

- maintain our focus on serving low-income families and individuals,
- increase our membership through internal growth, development of new plans and acquisitions,
- maintain our low medical costs, and
- leverage our operational efficiencies.

Our Company

Molina Healthcare, Inc. was 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. We intend to reincorporate in Delaware effecting a 40-for-1 stock split before the closing of this offering. 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 a part of this prospectus. Our company is the federally registered owner of the Molina service mark and name. All other product names, trademarks, service marks and trade names referred to are the property of their respective owners.

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THE OFFERING

Common stock offered	shares
Over-allotment option	shares
Common stock to be outstanding after this offering	shares
Use of proceeds	We intend to use the net proceeds of this offering primarily for selective acquisitions, enrollment initiatives and general corporate purposes, including working capital.
Proposed New York Stock Exchange symbol	MOH

In the table above, the number of shares of common stock to be outstanding after this offering is based on the number of shares outstanding as of September 30, 2002. This information excludes:

- 1,087,800 shares of common stock issuable upon the exercise of vested stock options with a weighted average exercise price of $1.47 per share,
- 405,760 shares of common stock issuable upon the exercise of unvested stock options with a weighted average exercise price of $4.45 per share,
- 1,600,000 shares of common stock reserved for issuance under our stock option plans,
- 600,000 shares of common stock reserved for issuance under the 2002 Employee Stock Purchase Plan, and
- the proposed redemption of approximately $20.0 million in common stock prior to the closing of this offering from certain of our stockholders, some of which are trusts, the remainder beneficiaries of which include directors and executive officers.

The information in this prospectus assumes the following:

- a 40-for-1 stock split of our outstanding common stock and recapitalization as a result of the exchange in the reincorporation merger to occur prior to the effectiveness of our registration statement with the Securities and Exchange Commission, and
- no exercise of the underwriters' over-allotment option.

In this prospectus "we," "us" and "our" refer to Molina Healthcare, Inc. and its direct and indirect subsidiaries.

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SUMMARY CONSOLIDATED FINANCIAL DATA

The following tables summarize consolidated financial data for our business. You should read the summary consolidated financial data set forth below together with “Management’s Discussion and Analysis of Financial Condition and Results of Operations” and our consolidated financial statements and the notes to those financial statements included elsewhere in this prospectus.

	Year Ended December 31,			Nine Months Ended September 30,	
	1999	2000(1)	2001(1)	2001(1)	2002(1)
	(dollars in thousands, except per share data)				
Statements of Income Data:					
Revenue:					
Premium revenue	$ 181,929	$ 324,300	$ 499,471	$ 368,245	$ 465,716
Other operating revenue	2,358	1,971	1,402	1,138	1,484
Investment income	1,473	3,161	2,982	2,488	1,330
Total operating revenue	185,760	329,432	503,855	371,871	468,530
Expenses:					
Medical care costs	148,138	264,408	408,410	300,667	386,572
Marketing, general and administrative expenses	18,511	38,701	42,822	31,392	37,844
Deprecation and amortization	1,625	2,085	2,407	1,760	2,669
Total expenses	168,274	305,194	453,639	333,819	427,085
Operating income	17,486	24,238	50,216	38,052	41,445
Total other expense, net	(1,190)	(197)	(561)	(521)	(269)
Income before income taxes	16,296	24,041	49,655	37,531	41,176
Provision for income taxes	6,576	9,156	19,453	14,703	15,576
Income before minority interest	9,720	14,885	30,202	22,828	25,600
Minority interest	(267)	79	(73)	97	—
Net income	9,453	14,964	30,129	22,925	25,600
Diluted net income per share	0.47	0.73	1.46	1.11	1.24
Cash dividends declared per share	—	0.05	—	—	—
Weighted average number of common shares and potential dilutive common shares outstanding (2)	20,173,000	20,376,000	20,572,000	20,561,000	20,720,000
Operating Statistics:					
Medical care ratio (3)	80.4%	81.0%	81.5%	81.4%	82.7%
Marketing, general and administrative expense ratio (4)	10.0%	11.7%	8.5%	8.4%	8.1%
Members (5)	199,000	298,000	405,000	388,000	478,000

(1) The operating results of the Washington health plan have been included in the consolidated statements of income for periods after December 31, 1999, the date of acquisition.
(2) The weighted average number of common shares and potential dilutive common shares outstanding for 1999 has been adjusted to reflect a share exchange in 1999 in which each share of Molina Healthcare of California (formerly Molina Medical Centers) was exchanged for 5,000 shares of Molina Healthcare, Inc. (formerly American Family Care, Inc.), and Molina Healthcare, Inc. became the parent company.
(3) 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.
(4) Marketing, general and administrative expense ratio represents such expenses as a percentage of total operating revenue.
(5) Number of members at end of period.

	As of December 31,			As of September 30,	
	1999	2000	2001	2002 Actual	2002 As Adjusted(1)
	(dollars in thousands)				
Balance Sheet Data:					
Cash and cash equivalents	$ 26,120	$ 45,785	$ 102,750	$ 130,601	
Total assets	101,636	102,012	149,620	195,992	
Long-term debt (including current maturities)	17,296	3,448	3,401	3,363	
Total liabilities	80,991	67,405	84,861	105,633	
Stockholders' equity	20,645	34,607	64,759	90,359	

(1) The as adjusted data give effect to our receipt of the net proceeds from the sale of shares of common stock offered by us at an assumed offering price of $ per share (the mid-point of the range) after deducting estimated underwriting discounts and commissions and estimated offering expenses.

RISK FACTORS

An investment in our common stock involves a high degree of risk. You should carefully consider the following factors and other information contained in this prospectus before you decide whether to invest in the shares. If any of the following risks actually occur, the market price of our common stock could decline and you may lose all or part of the money you paid to buy the shares. 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 Being A Regulated Entity

We are subject to extensive government regulation. Any changes to those regulations could cause us to modify our operations and could negatively impact our operating results.

Our business is extensively regulated by the states in which we operate and by the federal government. The laws and regulations governing our operations are generally intended to benefit and protect health plan members and providers rather than stockholders. The agencies administering these laws and regulations have broad latitude to enforce them. These laws and regulations along with the terms of our Medicaid and other revenue contracts with the state regulatory agencies regulate:

- how we do business,
- revenue and enrollment growth, and
- our marketing efforts.

These laws and regulations, and interpretations of these laws and regulations, are subject to frequent change. Changes in existing laws or regulations or the enactment of new laws or regulations or changing interpretations of applicable laws or regulations could affect the factors listed above as well as:

- impose additional capital requirements,
- increase or change our liability,
- limit our ability to acquire other health plans or increase the cost of making such acquisitions,
- increase our administrative and other costs,
- increase or decrease mandated benefits,
- force us to restructure our relationships with providers within our network,
- require us to implement additional or different programs and systems,
- further restrict or prohibit inducements to enroll or retain an enrollee,
- restrict or prohibit physician incentives designed to promote the delivery of quality care in a cost-effective manner, and
- impact the terms and conditions of our centralized service contracts that are critical to our administrative efficiency.

We also are subject to various routine and non-routine governmental reviews, audits and investigations. This oversight could result in the loss of the right to participate in certain programs, or the imposition of fines, penalties and other sanctions. In addition, disclosure of any adverse investigation or audit results or sanctions related to us could damage our reputation in various markets and make it more difficult for us to contract with government agencies or to attract new members.

Our failure to comply with government laws and regulations could subject us to civil and criminal penalties and limit our profitability and ability to participate in government sponsored programs.

Violation of the laws or regulations governing our operations 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/or our exclusion from participation in federal health care programs, including Medicaid and the State Children's Health Insurance Program, or SCHIP. These penalties or exclusions, were they to occur, could negatively affect our profitability and our ability to operate our business.

Federal law prohibits, among other things, an entity from offering, paying, soliciting or receiving, subject to certain exceptions and "safe harbors," any remuneration to induce the referral of individuals or the purchase (or the arranging for or recommending the purchase) of items or services for which payment may be made under federal and state health care programs, including Medicaid and SCHIP. These prohibitions are commonly referred to as fraud and abuse or anti-kickback laws. Certain of the fraud and abuse laws created civil penalties for, among other things, billing for medically unnecessary goods or services. The federal anti-kickback laws have been interpreted broadly by some courts, the Office of Inspector General, or OIG, the U.S. Department of Health and Human Services, or HHS, and administrative bodies. Most states have similar anti-kickback laws. Exceptions and safe harbors under state laws vary and have been infrequently interpreted by courts or regulatory agencies. Sanctions for violating these federal and state anti-kickback laws may include criminal and civil fines and exclusion from participation in federally-funded health care programs, including Medicaid and SCHIP.

The Health Insurance Portability and Accountability Act of 1996, or HIPAA, broadened the scope of fraud and abuse laws applicable to health care companies. HIPAA also establishes new enforcement mechanisms, including a whistle blower program. A new regulation promulgated pursuant to HIPAA imposes civil and criminal penalties for failure to comply with the health information privacy standards set forth in the regulation. Compliance with the privacy standards is required by April 14, 2003. The federal government has enacted, and state governments are enacting, other fraud and abuse laws as well. Our failure to comply with HIPAA or these other laws could result in criminal or civil penalties and exclusion from Medicaid, SCHIP or other governmental health care programs and could lead to the revocation of our licenses. These penalties or exclusions, were they to occur, could prevent us from operating our business and cause us to lose members.

In April 1998, our California health plan sent letters to its plan members in San Bernardino and Riverside Counties notifying them of a pending Medi-Cal (the California Medicaid program) program change and the need to reselect their current health plan primary care physician if they intended to stay with that physician. The California Department of Health Services, or DHS, contended that the letters violated state and federal marketing laws and the health plan's Medi-Cal contract. After reviewing the matter with DHS, our California health plan agreed in October 1998 to payment of a $6,000 penalty as well as the suspension of enrollment and marketing activities for sixty days in San Bernardino and Riverside Counties. Shortly following resolution with DHS, the OIG informed our California health plan that the federal agency believed that it also had jurisdiction over the matter. In December 2001, the health plan resolved the matter with the OIG by making a $600,000 payment to HHS and committing to maintain in place policies and procedures designed to ensure compliance with applicable state and federal laws and Medicaid program requirements.

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 amounts of members and revenue.

Compliance with new laws and regulations may require us to make unanticipated expenditures.

On June 14, 2002, CMS issued final Medicaid managed care regulations that implement the Balanced Budget Act of 1997, or the BBA, and formally repealed the rules that had been published in January 2001. The final regulations took effect August 13, 2002. States have until August 13, 2003 to assure that all aspects of their state Medicaid managed care operations, including contracts and waivers, are in compliance with the final rule provisions. These final rules provide states more flexibility in their administration of Medicaid managed care programs. At the same time, they also provide certain new patient protections for Medicaid managed care members. In addition, they establish a new "actuarially sound" standard for determining payments to managed care plans under state Medicaid contracts. In light of these recent developments, states may require changes in

the manner in which we currently conduct our business, which may lead to additional costs that we have not yet identified. Compliance costs related to these final regulations might reduce the amount of working capital that we have available for other expenditures.

Many of our activities involve the use or disclosure by us of confidential patient health information. The Secretary of HHS issued a final rule regarding health information privacy in December 2000, or the Privacy Rule. The Privacy Rule, which has a compliance deadline of April 14, 2003, imposes extensive requirements on the way in which health care providers, health plans, health care clearinghouses and their business associates use and disclose protected health information. The Privacy Rule gives individuals significant rights to understand and control how their protected health information is used and disclosed. Sanctions for failing to comply with the Privacy Rule standards include criminal penalties and civil sanctions.

On August 14, 2002, HHS issued final amendments to the Privacy Rule that took effect on October 15, 2002. In general, the final amendments reduce some, but not all, of the burdens imposed on health care providers and health plans contained in the Privacy Rule. The final amendments also add some new restrictions.

In addition to the Privacy Rule described above, most states have enacted confidentiality laws that limit the disclosure of confidential health information. The Privacy Rule does not preempt state laws regarding health information privacy that are more restrictive than the Privacy Rule.

In August 1998, HHS also issued proposed regulations pursuant to HIPAA that govern the security of confidential health information. A final security rule has not been published, and its publication date is yet to be determined. Once a final security rule is issued, it will likely impose additional administrative burdens on health care providers, health plans and their business associates, relating to the storage and utilization of, and access to, health information.

In August 2000, HHS issued final regulations, pursuant to HIPAA, establishing electronic data transaction and code set standards that health care providers, health care clearinghouses and health plans must use for health care claims and payment transactions that are submitted or received electronically. We are required to comply with these regulations by October 16, 2002, unless we submit a “plan” to the Secretary of HHS detailing how we will come into compliance, in which case the compliance deadline will be extended to October 16, 2003. We have submitted the required plan in order to delay the compliance deadline. If we are unable to implement a new information system in 2003 that is compliant with the federal and state requirements, or if our system fails, we may be subject to fines or penalties for our failure to comply.

Based on the assessment we have made to date regarding HIPAA compliance, we believe that the regulations will require substantial changes to our systems, policies and procedures, which may be costly and may decrease our working capital available for other expenditures.

The federal administration’s review of the HIPAA and other newly published regulations, the states’ ability to promulgate stricter rules, and uncertainty regarding many aspects of the regulations make compliance with the relatively new regulatory landscape difficult. Our existing programs and systems unmodified would not enable us to comply in all respects with these new Medicaid managed care regulations, and we are in the process of assessing the programs and systems that we will need to implement in order to comply with the new regulations. Further, compliance with these pervasive regulations will require changes to many of the procedures we currently use to conduct our business, which may lead to additional costs that we have not yet identified. We do not know whether the changes we plan to implement will be sufficient for our compliance with the final HIPAA requirements that will be ultimately adopted by HHS.

Changes in health care laws and regulations may reduce our profitability.

Changes in applicable laws and regulations are continually being considered and interpretations of existing laws and rules may also change from time to time, including changes that may reduce the number of people

enrolled in or eligible for federal and state health care programs, reduce the amount of reimbursement or payment to health plans under such programs, or reduce or increase our administrative or health care costs under such programs. The purpose of much of the recent statutory and regulatory activity has been to reduce the rate of increase in health care costs, including costs paid under the Medicaid program.

Numerous proposals have been or may be introduced in the Congress and state legislatures relating to health care reform. Congress has considered a comprehensive package of requirements for managed care plans commonly known as the Patient Bill of Rights, or PBOR. This legislation would, among other things, expand a patient's right to sue and impose mandatory external review of health plan coverage decisions. If PBOR legislation ever became law, it could expose us to increased costs and additional litigation risks.

Federal legislation has also been proposed to enable physicians to bargain collectively with managed health care organizations. If legislation of this type were passed, it would negatively affect our bargaining position with many of our providers and could result in an increase in our cost of providing medical benefits.

State legislatures are also considering various forms of managed care reform. Issues relating to managed care consumer protection standards, including physician collective bargaining rights, increased plan information disclosure, expedited appeals and grievance procedures, third party review of certain medical decisions, health plan liability, access to specialists, state law mandated prompt payment of certain provider claims and confidentiality of medical records continue to be under discussion.

New health care reform legislation or regulations may require us to change the way we operate our business. It is possible that the cost of compliance with future legislation or regulation could have a material adverse effect on our ability to operate under the various government sponsored programs, to continue to serve our members and to attract new members.

Reductions in Medicaid funding by the states 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 state and federal 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 state and federal budgetary constraints. Changes in Medicaid funding could, for example, reduce the number of persons enrolled or eligible, reduce the amount of reimbursement or payment levels, carve out certain benefits such as our pharmacy, behavioral health or other potentially profitable benefits, or increase our administrative or health benefit costs under such programs. In some cases, changes in funding could be made retroactively. We believe that reductions in Medicaid payments could substantially reduce our profitability. Further, 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.

If our government contracts or our subcontracts with government contractors are not renewed or are terminated, or the compensation methodologies under our contracts are changed, 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. In addition, most contracts are terminable without cause. Most contracts are for a specified period and are subject to non-renewal. For example, in California, we contract with Health Net, Inc. for Los Angeles County. Health Net's contract for Los Angeles County will terminate in 2004 unless Health Net prevails in a competitive bidding process for the contract. If Health Net does not prevail in the bidding process or Health Net's contract for Los Angeles County is terminated prior to 2004 with or without cause, or our subcontract with Health Net is terminated, we could lose all of our Los Angeles County Medi-Cal business, unless we make alternative arrangements. Absent earlier termination with or without cause, our Medi-Cal contracts for San Bernardino and Riverside Counties will also terminate in 2004, unless they are renewed. In

Washington, our Healthy Options contract will expire in December 2003, if not renewed. In Utah, our contract expires in June 2004. Effective July 1, 2002, this contract was amended to provide a 1-year stop-loss guarantee through June 30, 2003. 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 competitive bid process. If we are unable to renew, successfully rebid or compete for any of our government contracts, our business will suffer.

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. 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.

If a state fails to renew its federal waiver or demonstration project waiver, or fails to meet the BBA requirements for mandatory Medicaid managed care enrollment, our membership in that state will likely decrease.

States may mandate Medicaid enrollment into managed care programs under federal waivers or demonstration program waivers, or under the BBA without waivers if certain conditions are met. Generally, waivers and demonstration program waivers are approved for two or three year periods, respectively, and can be renewed on an ongoing basis by states with appropriate modifications. We have no control over this renewal process. If a state does not renew its waiver for a mandated program or if the renewal application is not approved, or if the state is not in compliance with the BBA requirements for mandatory Medicaid managed care enrollment, our business would suffer as a result of a likely decrease in membership.

We rely on the accuracy of eligibility lists provided by the government. Inaccuracies in those lists would negatively affect our results of operations.

Premium payments to us are based upon eligibility lists produced by the government. A state could require us to reimburse it for premiums paid to us based on an eligibility list that the state later discovers contains individuals who are not in fact eligible for a government sponsored program. Alternatively, a state could fail to pay us for members for whom we are entitled to payment. We are also exposed to these risks when we are a subcontractor to parties that rely on government eligibility lists. Our results of operations would suffer as a result of such reimbursement to the state if we had made related payments to providers and were unable to recoup such payments from the providers.

Risks Related To Our Business

Receipt of inadequate premiums would negatively impact our revenues and profitability.

Most of our revenues consist of fixed monthly payments per member. These payments are fixed by contract, and we are obligated during the contract period to provide or arrange for the provision of health care services as established by the state and federal governments. We have less control over costs related to the provision of health care than we do over our marketing, general and administrative expenses. Historically, our medical care costs as a percentage of premium and other operating revenue have fluctuated. For example, our medical care costs were 82.7% of our premium and other operating revenue in the first nine months of 2002 and 81.4% of our premium and other operating revenue in the first nine months of 2001. If premiums are not increased and medical care costs rise, our earnings could decrease. In addition, our actual medical care costs may exceed our estimated

costs. The premiums we receive under our current contracts may therefore be inadequate to cover all claims, which may cause our profits to decline.

If we were unable to effectively manage medical costs, our profitability would be reduced.

Our profitability depends, to a significant degree, on our ability to predict and effectively manage medical costs. Historically, there have been fluctuations in the medical care ratios of our health plans. 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, or IBNR. We, together with our independent actuaries, estimate our medical claims liabilities using actuarial methods based on historical data 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 IBNR estimates 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 IBNR may also affect our ability to take timely corrective actions, further exacerbating the extent of the negative impact on our results. If we estimate IBNR too conservatively, we understate our profits, which results in the risks of underpaying income taxes and inaccurate disclosure to the public in our periodic reports.

We generally maintain reinsurance to protect us against certain catastrophic medical claims. Our reinsurance policies generally provide reinsurance coverage of $1.0 million per member, subject to a deductible per member, ranging from $50,000 to $200,000. While we believe our reinsurance coverage is adequate, in the future such reinsurance coverage may be inadequate or unavailable to us or the cost of such reinsurance coverage may limit our ability to obtain it.

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

The acquisition of Medicaid contract rights and other health plans has accounted for a significant amount of our growth. Although we cannot predict our rate of growth as the result of acquisitions with any accuracy, we believe that acquisitions similar in nature to those we have historically executed will be important to our growth strategy. Many of the other potential purchasers of these assets have greater financial resources than we have. In addition, along with their Medicaid assets, many of the sellers are interested in selling other assets in which we may not have an interest or selling their companies, including their liabilities. In the future, we may be unable to identify suitable targets, complete acquisitions on terms favorable to us or obtain the necessary financing for these acquisitions. Further, to the extent we complete acquisitions, we may be unable to realize the anticipated benefits from acquisitions because of operational factors or difficulty in integrating the acquisition with the existing business.

We are generally required to obtain regulatory approval from one or more state agencies when making acquisitions. 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 comply with these regulatory requirements for an acquisition in a timely manner, or at all.

We intend to enter into a credit facility prior to the closing of this offering. Our covenants in that credit facility may require lender approval for certain acquisitions. If lender approval is delayed or denied, we may be unable to obtain sufficient additional capital resources for future acquisitions. If we are unable to effectively execute our acquisition strategy, we may be unable to grow our business and our profitability could decline.

In addition to the difficulties we may face in identifying and consummating acquisitions, we also will be required to integrate our acquisitions with our existing operations. This may include the integration of:

- additional employees who are not familiar with our operations,
- new provider networks, which may operate on different terms than 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 IBNR, accounting for goodwill and intangible assets, stock-based compensation and income tax matters.

Failure of any new business in which we engage would negatively impact our results of operations.

Start-up costs associated with establishing a new health plan can be substantial. For example, in order to obtain a certificate of authority in most jurisdictions, we must first establish a provider network, have systems in place and demonstrate our ability to be able to obtain a state contract and process claims. If we were unsuccessful in obtaining the necessary license, winning the bid to provide service or attracting members in numbers sufficient to cover our costs, the new business would fail. We also could be obligated by the state to continue to provide services for some period of time without sufficient revenue to cover our ongoing costs or recover start-up costs. The costs associated with starting up such a business could have a significant impact on our results of operations.

We may be unable to expand into some geographic areas without incurring significant additional costs.

We will likely incur additional costs if we enter into geographic areas or states where we do not currently operate. Our rate of expansion into such areas also may be inhibited by:

- the time and costs associated with obtaining an HMO license, if necessary, to operate in the area,
- our inability to develop a network of physicians, hospitals and other health care providers which meets our requirements and those of government regulators,
- the cost of providing health care services in that area,
- demographics and population density,
- additional capital needed to increase net equity requirements associated with growth, and
- competition, which increases the costs of recruiting and retaining members.

We have not yet determined the timing or sequence of our expansion into new areas. We may be unsuccessful in entering other areas or states. While we regularly consider acquisitions of health plans both in new and existing markets, we currently have no agreements, understandings or letters of intent with respect to any material acquisitions, except as described in this prospectus.

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

We have experienced rapid growth in the past several years. In 1998, we had total revenue of $135.9 million. In 2001, we had total revenue of $503.9 million.

Depending on acquisition and other opportunities, we expect to continue to grow rapidly. Continued growth could place a significant strain on our management and on other resources. If we are unable to manage our growth effectively, our financial condition and results of operations could be materially and adversely affected. Our ability to manage our growth effectively 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. We must also continue to take steps to provide resources to service our members as their numbers increase, including member support resources and programs. The provision of additional member support could result in additional burdens on our systems and resources. In addition, due to the initial substantial costs related to acquisitions, rapid growth could adversely affect our short-term profitability and liquidity.

If we are not able to participate in SCHIP or BHP programs, our growth rate may be limited.

SCHIP is a federal-state initiative designed to provide coverage for low-income children not otherwise covered by Medicaid or other insurance programs. Each of the 50 states has adopted a SCHIP program but many states are just beginning to implement them. These programs vary significantly from state to state and it is not clear precisely how they will ultimately be implemented. Some states have also recently begun to adopt basic health care programs, or BHPs, for the uninsured, a category of people generally with incomes above the federal poverty level but who cannot afford private health insurance. Participation in SCHIP and BHP programs and other programs for the uninsured that are similar to our existing programs are an important part of our growth strategy. If we fail to renew our SCHIP or BHP contracts or if states do not let us participate or we fail to win bids to participate in SCHIP or BHP programs, our growth strategy may be materially and adversely affected.

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, legislative reform and aggressive marketing practices by other managed care organizations. This environment has produced and will likely continue to produce significant pressures on the profitability of managed care companies. In our geographic markets, we compete for members principally on the basis of size, location and quality of provider network, benefits supplied, quality of service and reputation. We compete with a variety of other organizations, including other health plans and traditional Medicaid programs that reimburse providers as care is supplied. Some of the health plans with which we compete have substantially larger enrollments and greater financial and other resources than we do.

Many states, including California, Michigan, Utah and Washington, mandate enrollment in managed care health plans for all or some Medicaid beneficiaries. Subject to very limited exceptions, the federal government requires that Medicaid beneficiaries have a choice among managed care plans if enrollment is mandated. This type of mandated competition will impact our ability to increase our market share.

In addition, we are not allowed to market directly to potential Medicaid members in any of the states in which we operate. Where we have only recently entered a market or compete with health plans much larger than we are, we may be at a competitive disadvantage unless and until our member-focused programs, provider relations and other promotional activities create brand awareness.

Restrictions and covenants in our new credit facility may limit our ability to take actions.

We intend to secure a $75.0 million revolving credit facility prior to the closing of this offering which we plan to use for general corporate purposes, acquisitions and to finance the purchase of approximately $20.0 million in common stock by our contemplated employee stock ownership plan from certain of our stockholders, including a trust, the remainder beneficiaries of which include directors and executive officers. There is no assurance we will be able to secure such a credit facility. If we enter into such a credit facility, we expect that the documents will contain customary restrictions and covenants that may restrict our financial and operating flexibility.

Events beyond our control, such as prevailing economic conditions, changes in the competitive environment and changes in governmental regulations, could impair our operating performance, which could affect our ability to comply with the terms of the credit facility. If we were unable to comply with those terms or repay, refinance or restructure our obligations under the credit facility, the lenders could proceed against the collateral securing such indebtedness.

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, all 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.

If we are unable to maintain satisfactory relationships with our provider networks, our profitability could decline.

Our profitability depends, in large part, upon our ability to contract favorably with hospitals, physicians and other health care providers in appropriate numbers and at locations appropriate for our members in our geographic markets. In any particular market, however, providers could refuse to contract, demand higher payments or take other actions that could result in higher health care costs. In some markets, there may be a shortage of certain essential providers, such as obstetrics, due to major increases in medical malpractice insurance premiums or unavailability of such insurance. In some markets, certain providers, particularly hospitals, physician/hospital organizations or multi-specialty physician groups, may have significant market positions or near monopolies. If any of our key providers refuse or are otherwise unavailable to contract with us, use their market position to negotiate more favorable contracts or otherwise place us at a competitive disadvantage, our operating results could be adversely affected. Some non-contracted providers may demand payment at their full billed charges for emergency services, and will not accept the otherwise applicable Medicaid payment rates, or disputes may arise over whether certain emergency services must be rendered to our Medicaid or SCHIP beneficiaries under the U.S. Emergency Medical Treatment and Active Labor Act, or EMTALA. Such increased payments or disputes could adversely affect our operating results.

Our provider arrangements with primary care physicians, specialists and hospitals in our networks usually have one-year terms and automatically renew for successive one-year periods, subject to termination for cause by us based on uncured material breach by the provider, other specific provider conduct or other specific reasons. These contracts generally may also be cancelled by either party without cause upon 30 days to nine months prior written notice. We may be unable to continue to renew such contracts or enter into new contracts enabling us to service our members profitably. We will be required to establish acceptable provider networks prior to entering

new markets. Although we have established long-term relationships with many of our network providers, we may be unable to enter into agreements with providers in new markets on a timely basis or under favorable terms. If we are unable to retain our current provider contracts or enter into new provider contracts timely or on favorable terms, our profitability could decline.

Negative publicity regarding the managed care industry may adversely affect our business and operating results.

In recent years, the managed care industry has received considerable negative publicity. This publicity has led to increased review of industry practices, legislation, regulation and litigation. These factors may adversely affect our ability to market our services, require us to change our procedures or services, and increase the regulatory burdens under which we operate, further increasing the costs of doing business and adversely affecting our operating results.

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. Although our network providers are independent contractors, providers at our primary care clinics in California are our employees for whose acts we may be liable as an employer. Claimants also frequently allege that the managed care organization should be held responsible for alleged malpractice by the independent contractor providers. In addition, managed care organizations may be sued directly for various types of alleged negligence, for example, in connection with the credentialling of network providers or improper denials or delay of care. Finally, 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.

In addition to medical malpractice claims, we may be subject to other costly litigation. 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 $5 million per occurrence and an annual aggregate limit of $10 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.

Our primary care clinics may expose us to liability.

As an operator of primary care clinics, we may be subject to increased exposure to liability for acts or injuries occurring on our premises. In addition, as a direct employer of physicians and ancillary medical personnel, we may experience increased exposure to liability for acts or omissions by those employees. As a result of such exposure, we may incur significant expenses and may be unable to effectively operate our business.

Growth in the number of Medicaid beneficiaries may be countercyclical, which could cause our operating results and stock price to decline when general economic conditions are improving.

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. Conversely, this number 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 during periods in which stock prices in general are increasing.

Growth in the number of Medicaid beneficiaries during economic downturns could cause our operating results and stock price to decline if state and federal budgets decrease or do not increase.

Less favorable economic conditions may cause our membership to increase as more people become eligible to receive Medicaid benefits. 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 and our stock price could decline.

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

Our business is dependent on effective 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 impacted.

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, among other things, from operational disruptions, loss of members, difficulty in attracting new members, regulatory problems and increases in administrative expenses.

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 may suffer.

We have not completed implementation of our disaster recovery plan.

A significant portion of our information systems are located in Long Beach, California. We do not maintain a redundant site, although one is currently under construction in Pomona, California. We expect this back-up site to be operational in January 2003. Until our back-up site is operational, we are subject to increased risks from localized telecommunications, Internet and systems failure, which would negatively impact our business operations.

System failures and capacity constraints could result in a reduction of our services and hinder our regulatory compliance.

Our ability to provide acceptable levels of patient and provider service and regulatory reporting largely depends on the efficient and uninterrupted operation of our hardware, software and network infrastructure. Inadequacies in the performance and reliability of our information systems or external communication systems could result in interruptions in the availability of some or all of our services or increase response times for effecting patient and provider communications and regulatory reporting. This could lead to patient, provider and regulator dissatisfaction, loss of patients and providers and damage to our reputation, which could materially adversely affect our business, financial condition and results of operations.

Our systems and operations may be vulnerable to damage or interruption from:

- power loss, telecommunications or network failures, operator negligence, improper operation by employees, physical break-ins and other similar events,

- unauthorized access or electronic break-ins, or "hacking," and
- computer viruses.

Breaches of our security systems could have a material adverse impact on our business and operations.

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 could theoretically 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.

Risks Associated With This Offering

There has been no public market, and we cannot guarantee that a trading market will develop or be maintained, for our common stock, and you may not be able to resell shares of our common stock for an amount equal to or more than your purchase price.

Prior to this offering there has not been a public market for our common stock. We cannot predict the extent to which a trading market will develop or how liquid that market might become, or whether it will be maintained. The initial public offering price will be determined by negotiation between the representatives of the underwriters and us and may not be indicative of prices that will prevail in the trading market. If an active trading market fails to develop or be maintained you may be unable to sell the shares of common stock purchased in this offering at an acceptable price or at all.

Volatility of our stock price could adversely affect stockholders.

The market price of our common stock could fluctuate significantly as a result of:

- state and federal budget decreases,
- adverse publicity regarding HMOs 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.

Investors may not be able to resell their shares of our common stock following periods of volatility because of the market's adverse reaction to such volatility. 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.

You will experience immediate and significant dilution in the book value per share and will experience further dilution with the future exercise of stock options.

If you purchase common stock in this offering, you will incur immediate dilution, which means that:

- you will pay a price per share that exceeds by $ the per share pro forma net tangible book value of our assets immediately following the offering (on a pro forma basis as of September 30, 2002), after giving effect to the exercise of vested options to purchase shares of common stock, and
- the investors in the offering will have contributed % of the total amount to fund us but will own only % of our outstanding shares of our common stock.

As of September 30, 2002, we had outstanding options to purchase 1,493,560 shares of our common stock, of which 1,087,800 were vested. On November 7, 2002, 735,200 of the options were settled with two executives through cash payments of $8,683,400. All previously unvested options will vest upon the closing of this offering. From time to time, we may issue additional options to employees pursuant to our equity incentive plans. These options generally vest commencing one year from the date of grant and continue vesting over a three to five year period. Once these options vest, you will experience further dilution as these stock options are exercised by their holders.

Our management has broad discretion to spend the net proceeds of this offering and may spend the proceeds in ways with which you may not agree.

Our business plan is general in nature and is subject to change based upon changing conditions and opportunities. Our management will retain broad discretion to expend a significant portion of the net proceeds of this offering. Because of the number and variability of factors that will determine the use of these proceeds, our actual allocation of the proceeds may vary substantially from our current intentions. If management fails to use the proceeds effectively, our operating results could suffer. See "Use of Proceeds" below for a more detailed description of how management intends to apply the proceeds from this offering.

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

In connection with this offering, we, along with our officers, directors, stockholders and optionholders, will have agreed prior to the commencement of this offering, subject to limited exceptions, not to sell or transfer any shares of common stock for 180 days after the date of this prospectus without the underwriters' consent. However, the underwriters may release these shares from these restrictions at any time. In evaluating whether to grant such a request, the underwriters may consider a number of factors with a view toward maintaining an orderly market for, and minimizing volatility in the market price of, our common stock. These factors include, among others, the number of shares involved, recent trading volume and prices of the stock, the length of time before the lock-up expires and the reasons for, and the timing of, the request. We cannot predict what effect, if any, market sales of shares held by any stockholder or the availability of these shares for future sale will have on the market price of our common stock.

Based on shares outstanding as of September 30, 2002, a total of shares of common stock may be sold in the public market by existing stockholders 181 days after the date of this prospectus, subject to applicable volume and other limitations imposed under federal securities laws. Sales of substantial amounts of our common stock in the public market after the completion of this offering, 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. See “Shares Eligible for Future Sale” below for a more detailed description of the restrictions on selling shares of our common stock after this offering.

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

Upon completion of this offering, our executive officers and directors will, in the aggregate, beneficially own approximately % of our capital stock. Members of the Molina family (some of whom are also officers or directors) will, in the aggregate, beneficially own approximately % of our capital stock, either directly or in trusts of which members of the Molina family are trustees, beneficiaries or both. As a result, Molina family members, acting themselves or together with our officers and directors, will have the ability to influence our management and affairs and the outcome of matters submitted to stockholders for approval, including the election and removal of directors, amendments to our charter and any merger, consolidation or sale of all or substantially all of our assets.

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

Delaware corporate law, state laws to which we are subject and our certificate of incorporation and bylaws 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 you and other 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,
- 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, and
- a stockholder rights plan.

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

FORWARD-LOOKING STATEMENTS

This prospectus contains forward-looking statements that involve risks and uncertainties. These forward-looking statements are often accompanied by words such as “believe,” “anticipate,” “plan,” “expect,” “estimate,” “intend,” “seek,” “goal,” “may,” “will,” and similar expressions. These statements include, without limitation, statements about our market opportunity, our growth strategy, competition, expected activities and future acquisitions and investments and the adequacy of our available cash resources. These statements may be found in the sections of this prospectus entitled “Prospectus Summary,” “Risk Factors,” “Use of Proceeds,” “Management’s Discussion and Analysis of Financial Condition and Results of Operations” and “Business.” Investors are cautioned that matters subject to forward-looking statements involve risks and uncertainties, including economic, regulatory, competitive and other factors that may affect our business. These statements are not guarantees of future performance and are subject to risks, uncertainties and assumptions.

Actual results may differ from projections or estimates due to a variety of important 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 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 (including benefit mandates) and reform 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.

USE OF PROCEEDS

We estimate that we will receive net proceeds from the sale of the shares of common stock in this offering of $ million, assuming an initial public offering price of $ per share (the midpoint of the range) and after deducting estimated underwriting discounts and commissions and estimated offering expenses. If the underwriters exercise their over-allotment option in full, we estimate that our net proceeds will be $ million.

The principal purposes of this offering are to obtain additional capital, to create a public market for our common stock and to facilitate future access to public debt and equity markets. As of the date of this prospectus, we have no specific plans to use the net proceeds from this offering other than as set forth below:

- pursue selective acquisitions of health plans and contracts for government sponsored health programs in existing and new markets,
- increase our enrollment in existing markets through enrollment initiatives, and
- general corporate purposes, including working capital.

We have not determined the amount of net proceeds to be used specifically for the foregoing purposes. As a result, management will have broad discretion over the use of the proceeds from this offering. Pending any such uses, we intend to invest the net proceeds in interest bearing securities.

DIVIDEND POLICY

We have in the past declared and paid cash dividends on our common stock. The dividends declared were $0 in 2001, $1,000,000 in 2000 and $0 in 1999, 1998 and 1997. 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 is dependent on cash dividends from our subsidiaries. Laws of the states in which we operate or may operate, as well as requirements of the government sponsored health programs in which we participate, limit the ability of our subsidiaries to pay dividends to us. In addition, if we enter into a credit facility as currently contemplated, the terms of that facility may also limit our ability to pay dividends.

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CAPITALIZATION

The following table shows our cash, cash equivalents and capitalization, as of September 30, 2002:

- on an actual basis, unadjusted for any exercise of outstanding options, and
- on an as adjusted basis to reflect the issue and sale of shares of common stock by us in this offering at an assumed initial offering price of $ per share less estimated underwriting discounts and commissions and estimated offering expenses payable by us.

You should read the following table in conjunction with "Management's Discussion and Analysis of Financial Condition and Results of Operations" and our consolidated financial statements and related notes appearing elsewhere in this prospectus.

	September 30, 2002	
	Actual	As Adjusted
	(dollars in thousands, except per share data)	
Cash and cash equivalents	$ 130,601	
Long-term debt (including current maturities)	3,363	
Stockholders' equity		
Common stock, $0.001 par value; 80,000,000 shares authorized; 20,000,000 shares issued and outstanding, actual; issued and outstanding, as adjusted	5	
Preferred stock, $0.001 par value; 20,000,000 shares authorized; no shares issued and outstanding, actual or as adjusted	—	
Retained earnings	90,354	
Total stockholders' equity	90,359	
Total capitalization	93,722	

DILUTION

If you invest in our common stock, your interest will be diluted to the extent of the difference between the public offering price per share of our common stock and the pro forma net tangible book value per share of common stock after giving effect to this offering.

Our pro forma net tangible book value as of September 30, 2002 was $85.1 million or $4.04 per share of common stock after giving effect to the exercise of options to purchase shares of common stock that were vested as of September 30, 2002. Pro forma net tangible book value per share is determined by dividing net tangible book value, which is our total tangible assets less total liabilities, by the pro forma number of shares of common stock outstanding. Assuming the sale of shares of common stock in this offering at an assumed initial public offering price of $ per share, our pro forma as adjusted net tangible book value as of September 30, 2002 would have been $ million, or $ per share of common stock. This represents an immediate increase in the pro forma net tangible book value of $ per share to our existing stockholders and an immediate dilution in the pro forma net tangible book value of $ per share to new investors purchasing shares in this offering.

Dilution per share represents the difference between the price per share to be paid by new investors and the pro forma as adjusted net tangible book value per share immediately after this offering. The following table illustrates this dilution on a per share basis.

Assumed initial public offering price per share	$	
Pro forma net tangible book value per share as of September 30, 2002	$	4.04
Increase per share attributable to this offering	$	
Pro forma as adjusted net tangible book value per share after this offering	$	
Dilution per share to new investors	$	

The following table sets forth, on a pro forma basis to reflect the adjustments described above, as of September 30, 2002, the total consideration paid to us and the average price per share paid by existing stockholders and by new investors purchasing shares of common stock in this offering at an assumed initial public offering price of $ per share, before deducting the estimated underwriting discounts and commissions and estimated offering expenses:

	Shares Purchased		Total Consideration	
	Amount	Percent	Amount	Percent
Existing Stockholders		%	$	%
New Investors		%	$	%
Total		100%	$	100%

As of September 30, 2002, we had outstanding options to purchase 1,493,560 shares of common stock with a weighted average exercise price of $2.28 per share, of which 1,087,800 were vested. On November 7, 2002, 735,200 options were settled with two executives through cash payments totaling $8,683,400. All previously unvested options will become fully vested upon the closing of this offering.

SELECTED CONSOLIDATED FINANCIAL DATA

The following selected consolidated financial data for the five years ended December 31, 2001 are derived from our audited consolidated financial statements. The financial data for the nine-month periods ended September 30, 2001 and 2002 are derived from our unaudited financial statements. The unaudited financial statements include all adjustments, consisting of normal recurring accruals, which we consider necessary for a fair presentation of the financial position and the results of operations for these periods. Operating results for the nine months ended September 30, 2002 are not necessarily indicative of the results that may be expected for the entire year ending December 31, 2002. The data should be read in conjunction with our consolidated financial statements, related notes, and other financial information included herein.

	Year Ended December 31,					Nine Months Ended September 30,	
	1997	1998	1999	2000(1)	2001(1)	2001(1)	2002(1)
	(dollars in thousands, except per share data)						
Statements of Income Data:							
Revenue:							
Premium revenue	$ 113,799	$ 132,117	$ 181,929	$ 324,300	$ 499,471	$ 368,245	$ 465,716
Other operating revenue	2,383	2,911	2,358	1,971	1,402	1,138	1,484
Investment income	753	863	1,473	3,161	2,982	2,488	1,330
Total operating revenue	116,935	135,891	185,760	329,432	503,855	371,871	468,530
Expenses:							
Medical care costs	106,166	116,149	148,138	264,408	408,410	300,667	386,572
Marketing, general and administrative expenses	10,778	12,708	18,511	38,701	42,822	31,392	37,844
Depreciation and amortization	1,258	1,333	1,625	2,085	2,407	1,760	2,669
Total expenses	118,202	130,190	168,274	305,194	453,639	333,819	427,085
Operating income (loss)	(1,267)	5,701	17,486	24,238	50,216	38,052	41,445
Total other expense, net	(54)	(1,051)	(1,190)	(197)	(561)	(521)	(269)
Income (loss) before income taxes	(1,321)	4,650	16,296	24,041	49,655	37,531	41,176
Provision (benefit) for income taxes	(325)	2,157	6,576	9,156	19,453	14,703	15,576
Income (loss) before minority interest	(996)	2,493	9,720	14,885	30,202	22,828	25,600
Minority interest	—	68	(267)	79	(73)	97	—
Net income (loss)	(996)	2,561	9,453	14,964	30,129	22,925	25,600
Diluted net income (loss) per share	(0.05)	0.13	0.47	0.73	1.46	1.11	1.24
Cash dividends declared per share	—	—	—	0.05	—	—	—
Weighted average number of common shares and potential dilutive common shares outstanding (2)	20,000,000	20,000,000	20,173,000	20,376,000	20,572,000	20,561,000	20,720,000
Operating Statistics:							
Medical care ratio (3)	91.4%	86.0%	80.4%	81.0%	81.5%	81.4%	82.7%
Marketing, general and administrative expense ratio (4)	9.2%	9.4%	10.0%	11.7%	8.5%	8.4%	8.1%
Members (5)	110,000	162,000	199,000	298,000	405,000	388,000	478,000

	As of December 31,					As of September 30,	
	1997	1998	1999(1)	2000(1)	2001(1)	2002 Actual(1)	2002 As Adjusted(6)
	(dollars in thousands, except per share data)						
Balance Sheet Data:							
Cash and cash equivalents	$ 5,745	$ 6,251	$ 26,120	$ 45,785	$ 102,750	$ 130,601	
Total assets	30,300	38,223	101,636	102,012	149,620	195,992	
Long-term debt (including current maturities)	1,000	57	17,296	3,448	3,401	3,363	
Total liabilities	21,661	27,028	80,991	67,405	84,861	105,633	
Stockholders' equity	8,639	11,195	20,645	34,607	64,759	90,359	

(1) The balance sheet and operating results of the Washington health plan have been included in the consolidated balance sheet as of December 31, 1999, the date of acquisition, and in each of the consolidated statements of income for periods thereafter.
(2) The weighted average number of common shares and potential dilutive common shares outstanding for 1999 and prior has been adjusted to reflect a share exchange in 1999 in which each share of Molina Healthcare of California (formerly Molina Medical Centers) was exchanged for 5,000 shares of Molina Healthcare, Inc. (formerly American Family Care, Inc.), and Molina Healthcare, Inc. became the parent company.
(3) 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.
(4) Marketing, general and administrative expense ratio represents such expenses as a percentage of total operating revenue.
(5) Number of members at end of period.
(6) The as adjusted data give effect to our receipt of the net proceeds from the sale of shares of common stock offered by us at an assumed offering price of $ per share (the mid-point of the range) after deducting estimated underwriting discounts and commissions and estimated offering expenses.

MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

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 prospectus. The following discussion contains forward-looking statements based upon current expectations and related to future events and our future financial performance that involve risks and uncertainties. Our actual results and timing of events could differ materially from those anticipated in these forward-looking statements as a result of many factors, including those set forth under "Risk Factors," "Forward-Looking Statements" and "Business" and elsewhere in this prospectus.

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.

The following outlines significant milestone events for our company:

1980-1982	We opened three primary care clinics in Long Beach, California, providing health care to Medicaid beneficiaries.
1985	We obtained contracts to provide managed care services on a risk-sharing basis with the state of California.
1989	We purchased nine primary care clinics in California.
1994	We obtained an HMO license in California and were awarded a contract to participate in the state's managed care program for Sacramento County.
1995	We successfully negotiated Medicaid contracts for the counties with three of the largest Medicaid populations in California — San Bernardino, Riverside and Los Angeles (as a subcontractor to Health Net, Inc.).
1997	We established operations in Utah.
1998-1999	We acquired a minority interest in the predecessor companies to our Michigan health plan in 1998. In May 1999, we acquired a controlling interest in that plan.
1999	We acquired our Washington health plan, giving us an additional 60,000 members.
2001	Our enrollment reached 405,000 members at December 31, 2001.

We generate revenues primarily from premiums we receive from the states in which we operate. In 2001 we received approximately 93% 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 are recognized as premium revenue during the period in which we are obligated to provide services to our members. We also received approximately 7% of our premium revenue from the Medicaid programs in Washington, Michigan and Utah for newborn deliveries, or birth income, on a per case basis.

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 in each of our service areas in the periods presented.

Market	As of December 31, 1999	As of December 31, 2000	As of December 31, 2001	As of September 30, 2002
California	168,000	184,000	229,000	252,000
Michigan	23,000	22,000	26,000	29,000
Utah	8,000	13,000	16,000	40,000
Washington	—(1)	79,000	134,000	157,000
Total	199,000	298,000	405,000	478,000

(1) We acquired the Washington health plan on December 31, 1999, which had approximately 60,000 members on the date of acquisition.

Our operating expenses include expenses related to medical care services and marketing, general and administrative, or MG&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. For the year ended December 31, 2001, approximately 72% 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 our contracts with our providers. We pay hospitals in a variety of ways, including fee-for-service, per diems, diagnostic related groups, or DRGs, and case rates.

Medical care costs include 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 use the service of independent actuaries to review our estimates monthly and certify them quarterly. We believe our process for estimating IBNR is adequate, but there can be no assurance that medical care costs will not exceed such estimates.

MG&A costs are largely comprised of wage and benefit costs related to our employee base and other administrative expenses. Some of these 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 and legal and regulatory. Locally provided functions include marketing, plan administration and provider relations. Included in MG&A expenses are premium taxes for the Washington health plan as the state of Washington assesses taxes based on premium revenue rather than income.

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 operating 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,			Nine Months Ended September 30,	
	1999	2000	2001	2001	2002
Premium revenue	97.9%	98.4%	99.1%	99.0%	99.4%
Other operating revenue	1.3%	0.6%	0.3%	0.3%	0.3%
Investment income	0.8%	1.0%	0.6%	0.7%	0.3%
Total operating revenue	100.0%	100.0%	100.0%	100.0%	100.0%
Medical care ratio	80.4%	81.0%	81.5%	81.4%	82.7%
Marketing, general and administrative expenses	10.0%	11.7%	8.5%	8.4%	8.1%
Operating income	9.4%	7.4%	10.0%	10.2%	8.9%
Net income	5.1%	4.5%	6.0%	6.2%	5.5%

Nine Months Ended September 30, 2002 Compared to Nine Months Ended September 30, 2001

Premium Revenue

Premium revenue for the nine months ended September 30, 2002 increased 26.5% to $465.7 million from $368.2 million for the same period of the prior year. The increase was attributed to membership growth of 23.2% to 478,000 members at September 30, 2002 from 388,000 members at the same date of the prior year, rate increases provided in California, Washington and Utah and increased revenues under the revised contract with the state of Utah which became effective July 1, 2002.

Medical Care Costs

Medical care costs for the nine months ended September 30, 2002 increased 28.6% to $386.6 million from $300.7 million for the same period of the prior year. The increase in costs is primarily attributed to the 23.2% growth in membership. The medical care ratio for the nine months ended September 30, 2002 increased to 82.7% from 81.4% for the same period of the prior year. The increase in medical care ratio is due to overall increase in inpatient and specialty costs in California, Washington and Utah. Increased specialty costs are primarily due to an increase in emergency room visits and outpatient surgeries. The increased costs in Utah were partially offset by higher revenues under the stop-loss guarantee contract which became effective July 1, 2002.

Marketing, General and Administrative Expenses

MG&A expenses for the nine months ended September 30, 2002 increased 20.6% to $37.8 million from $31.4 million for the same period of the prior year. The $6.4 million increase was primarily due to an increase in the number of employees required to support our membership growth. Our MG&A expense ratio was 8.1% for the nine months ended September 30, 2002, which is lower than the 8.4% experienced in the same period of the prior year.

Provision for Income Taxes

Income taxes totaled $15.6 million in the nine months ended September 30, 2002, resulting in an effective tax rate of 37.8%. Income taxes totaled $14.7 million for the nine months ended September 30, 2001, resulting in an effective tax rate of 39.2%. The reduction in the effective tax rate is due to increased earnings generated from

Washington which is not subject to state income taxes but instead assesses taxes based on premium revenue. Premium taxes are included in MG&A expenses.

Year Ended December 31, 2001 Compared to Year Ended December 31, 2000

Premium Revenue

Premium revenue for 2001 increased 54.0% to $499.5 million from $324.3 million in 2000. The increase was attributed to membership growth of 35.9% to 405,000 members at December 31, 2001 from 298,000 members at the same date of the prior year. Membership grew in all of our plans during this period, but the increases were most significant in Washington and California, where membership grew 69.6% and 24.5%, respectively. Membership growth in Washington also contributed to increased consolidated revenue as premiums on a per member per month basis are higher in Washington than in California. Additionally, birth income, which is included in premium revenue, increased $18.6 million in 2001 as compared to 2000 as a result of higher enrollment.

Medical Care Costs

Medical care costs for 2001 increased 54.5% to $408.4 million from $264.4 million in 2000. The increase in costs is largely attributable to growth in membership. Our medical care ratio for 2001 increased to 81.5% from 81.0% in 2000 due to increased specialty utilization and higher inpatient costs per day per member in California, and higher medical utilization in Utah.

Marketing, General and Administrative Expenses

MG&A expenses in 2001 increased 10.6% to $42.8 million from $38.7 million in 2000. As a percentage of total operating revenue, MG&A decreased from 11.7% to 8.5%. The growth in expenses was due to increased state premium taxes incurred by our Washington health plan due to enrollment increases and additional administrative expenses in supporting membership growth, partially offset by reduced expenses associated with our systems conversion, which we completed in 2000.

Provision for Income Taxes

Income taxes totaled $19.5 million in 2001, resulting in an effective tax rate of 39.2%. Income taxes totaled $9.2 million for 2000, resulting in an effective tax rate of 38.1%. The lower tax rate in 2000 resulted from the reversal of a $645,000 non-deductible accrual.

Year Ended December 31, 2000 Compared to Year Ended December 31, 1999

Premium Revenue

Premium revenue for 2000 increased 78.3% to $324.3 million from $181.9 million in 1999. The increase was primarily attributed to the Washington health plan acquisition which increased 2000 premium revenue by $102.6 million. Excluding the Washington health plan acquisition, premium revenue for 2000 increased 21.9%. Contributing to the growth in premium revenue were membership growth and rate increases in California and Utah, the acquisition of the majority interest in our Michigan health plan and a subsequent increase in services offered under that plan.

Medical Care Costs

Medical care costs for 2000 increased 78.5% to $264.4 million from $148.1 million in 1999. The increase in costs is largely attributable to the addition of the Washington health plan (which accounts for $84.0 million of the medical care costs) and the remainder is largely due to membership growth primarily in California. Our medical

care ratio for 2000 increased to 81.0% from 80.4% in 1999. This was primarily the result of the acquisition of the Washington health plan which carried a higher medical care ratio in 2000 than our overall medical care ratio in 1999, but that was largely offset by a reduction of the medical care ratio in California in 2000.

Marketing, General and Administrative Expenses

MG&A expenses in 2000 increased 109.1% to $38.7 million from $18.5 million in 1999. Our MG&A expense ratio was 11.7% for 2000 compared to 10.0% in 1999. Of the $20.2 million increase in 2000, approximately $14.5 million is attributable to administrative costs associated with the Washington health plan which was acquired on December 31, 1999, and the balance is largely attributable to the one-time expenses relating to the conversion of our Washington health plan to our information and accounting systems.

Provision for Income Taxes

Income taxes totaled $9.2 million in 2000, resulting in an effective tax rate of 38.1%. Income taxes totaled $6.6 million for 1999, resulting in an effective tax rate of 40.4%. The lower 2000 effective tax rate resulted from a higher proportion of our consolidated income earned by our Washington health plan in 2000, which is not subject to state income taxes and the reversal of a $645,000 non-deductible accrual. In 1999, all of our income was subject to state income taxes. In addition, we recorded a $1.0 million non-deductible accrual, although the higher tax rate was partially offset by an increase in the recorded value of net operating loss benefits available to us.

Liquidity and Capital Resources

Since our formation, we have principally financed our operations and growth through internally generated funds. We generate cash from premium revenue, services provided on a fee-for-service basis at our clinics and investment income. Our primary uses of cash include the payment of expenses related to medical care services and MG&A expenses. From time to time, we may need to raise capital, and draw on the credit facility we intend to procure prior to the closing of this offering, to fund planned geographic and product expansion and for acquisitions of health care businesses. We generally receive premium revenue in advance of payment of claims for related health care services.

Our investment policies are designed to provide liquidity, preserve capital and maximize total return on invested assets. As of September 30, 2002, we invested a substantial portion of our cash in a portfolio of highly liquid money market securities. The states in which we operate prescribe the types of instruments in which our subsidiaries may invest their funds. The average portfolio yield for the nine months ended September 30, 2002 was approximately 1.2%.

Net cash provided by operations increased from $15.1 million in 1999 to $21.6 million in 2000 and $61.4 million in 2001. Net cash provided by operations for the nine months ended September 30, 2002 was $34.5 million. The growth in cash from operations was primarily due to increased membership, improved profitability and changes in outstanding receivables and liabilities based on the timing of cash receipts and payments. Because we generally receive premium revenue in advance of payment for the related medical care costs, our cash available 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 September 30, 2002, we had working capital of $69.6 million as compared to working capital of $20.3 million and $49.1 million at December 31, 2000 and 2001, respectively.

At September 30, 2002, December 31, 2001 and December 31, 2000, cash and cash equivalents were $130.6 million, $102.8 million and $45.8 million, respectively.

Our subsidiaries are required to maintain minimum capital requirements prescribed by various jurisdictions in which we operate. Our restricted investments are invested principally in certificates of deposit and treasury

securities with maturities of up to twelve months. As of September 30, 2002, 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 2002. 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 12 months following this offering.

We intend to secure a $75.0 million credit facility prior to the closing of this offering which we plan to use for general corporate purposes, acquisitions and to finance the purchase of approximately $20.0 million of common stock by our contemplated employee stock ownership plan. There is no assurance that we will be able to secure such a credit facility.

Redemption and Employee Stock Ownership Plan

Prior to the closing of this offering, we intend to complete two transactions with respect to our common stock.

First, we intend to redeem from certain of our stockholders, some of which are trusts, the remainder beneficiaries of which include directors and executive officers, approximately $20.0 million of our common stock using available cash reserves. The terms of the redemption are not yet finalized.

Second, we intend to establish an employee stock ownership plan, ESOP, that will enable eligible employees to acquire ownership interests in our common stock. The ESOP will be administered by an independent trustee. We intend to borrow funds under our proposed credit facility and, in turn, loan the funds to the ESOP trustee for the purchase of approximately $20.0 million of our common stock from certain of our stockholders, including a trust, the remainder beneficiaries of which include directors and executive officers. The terms of the proposed credit facility, the loan to the ESOP trustee and the sale of shares by certain shareholders to the ESOP trustee are not yet finalized.

Regulatory Capital and Dividend Restrictions

Our principal operations are conducted through the four HMOs operating in California, Washington, Michigan and Utah. 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 stockholders.

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

As of September 30, 2002, our HMOs had aggregate statutory capital and surplus of approximately $75.1 million, compared with the required minimum aggregate statutory capital and surplus requirements of approximately $29.6 million. All our HMOs 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 2002.

Critical Accounting Policies

Our significant accounting policies are more fully described in Note 2 to our consolidated financial statements. However, one of our accounting policies is particularly important to the portrayal of our financial

position and results of operations and requires the application of significant judgment by our management; as a result, it is subject to an inherent degree of uncertainty.

Our medical care costs include estimates for medical care costs incurred but not reported to us, or IBNR. We, together with our independent actuaries, estimate medical claims liabilities using actuarial methods based upon historical data 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. We also record reserves for estimated referral claims related to medical groups under contract with us who are financially troubled or insolvent and who may not be able to honor their obligations for the costs 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, our management uses judgment to determine the appropriate assumptions to be used in the determination of 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 the medical claims liabilities, we consider our historical experience, terms of existing contracts, our observance of trends in the industry, information provided by our customers and information available from other outside sources as appropriate.

Commitments and Contingencies

We lease office space and equipment under various operating leases, and to a lesser extent, capital lease arrangements. As of September 30, 2002, our combined lease obligations for the next five years and thereafter are as follows: $0.9 million in 2002, $3.0 million in 2003, $2.4 million in 2004, $2.0 million in 2005, $1.7 million in 2006 and an aggregate of $4.7 million in 2007 and thereafter. Subsequent to September 30, 2002, our California subsidiary entered into a lease with the following obligations for the next five years and thereafter: $0.2 million in 2002, $0.9 million in 2003, $0.9 million in 2004, $1.0 million in 2005, $1.0 million in 2006 and an aggregate of $6.9 million in 2007 and thereafter.

Our headquarters building in Long Beach, California is subject to a mortgage as of September 30, 2002 of $3.4 million.

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 prospectus and the notes thereto. We have made certain advances and loans to related parties which are discussed in the “Related Party Transactions” section of this prospectus and in the consolidated financial statements appearing elsewhere in this prospectus and the notes thereto.

Recent Accounting Pronouncements

In June 2001, Statements of Financial Accounting Standards, or SFAS, No. 141, Business Combinations, was issued which requires that the purchase method of accounting be used for all business combinations completed after June 30, 2001. We have adopted SFAS No. 141.

In June 2001, SFAS No. 142, Goodwill and Other Intangible Assets, was issued which requires that goodwill and intangible assets with indefinite useful lives no longer be amortized, but instead be tested at least annually for impairment. We have adopted SFAS No. 142 effective January 1, 2002. Except for the discontinuance of goodwill amortization, there was no significant impact on our financial position, results of operations or cash flows. For the year ended December 31, 2001, goodwill amortization was $299,000.

In August 2001, SFAS No. 144, Accounting for the Impairment or Disposal of Long-Lived Assets, was issued which provides updated guidance concerning the recognition and measurement of an impairment loss for certain types of long-lived assets. It also expands the scope of a discontinued operation to include a component of an entity. We have adopted SFAS No. 144 effective January 1, 2002. The adoption of SFAS No. 144 did not affect our financial position, results of operations or cash flows.

Quantitative and Qualitative Disclosures About Market Risk

As of September 30, 2002, we had cash and cash equivalents of $130.6 million and restricted investments of $2.0 million. The cash equivalents consist of highly liquid securities with original maturities of up to three months and the restricted investments consists 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 to 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

According to U.S. Bureau of Labor Statistics Data, the national health care cost inflation rate has exceeded the general inflation rate for the last four years. 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

HIPAA, the federal law designed to protect health information, contemplates establishment of physical and electronic security requirements for safeguarding health information. HHS has not finalized regulations establishing security requirements for health information, and their publication date is yet to be determined. Due to the uncertainty surrounding the regulatory requirements, implementation of additional systems and programs may be required, the cost of which is unknown to us at this time. Such requirements may lead to additional costs that we have not yet identified.

BUSINESS

Overview

We are a rapidly growing, 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 by C. David Molina, M.D. as a provider organization serving the Medicaid population through a network of primary care clinics in California. We recognized the growing need for the effective management and delivery of health care services to underserved Medicaid beneficiaries and expanded our business to operate as an HMO. We have grown rapidly over the past several years by taking advantage of attractive expansion opportunities. We established a Utah health plan in 1997, and later acquired health plans in Michigan and Washington. As of September 30, 2002, we had approximately 478,000 members.

Low-income families and individuals have distinct social and medical needs and are characterized by their cultural, ethnic and linguistic diversity. From our inception, we have designed the company to work with government agencies to serve low-income populations. Our success has resulted from our expertise in working with government programs, experience with low-income members, 22 years of owning and operating primary care clinics, our cultural and linguistic expertise and our focus on operational and administrative efficiency.

Our annual revenue has increased from $135.9 million in 1998 to $503.9 million in 2001. Over the same period, our net income grew at a greater rate from $2.6 million to $30.1 million due to our effective medical management programs and our ability to leverage fixed costs. In California, our largest market, we have gained market share and increased profitability in an environment characterized by significant competition, heavy regulation and the lowest state Medicaid expenditure rate per beneficiary in the U.S. We believe our experience, administrative efficiency, proven ability to replicate a disciplined business model in new markets and ability to customize local provider contracts position us well for continued growth and success.

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. In 2001, according to information published by the Kaiser Commission on Medicaid and the Uninsured, Medicaid covered approximately 44.6 million individuals, with 51% of those being children. The federal Centers for Medicare and Medicaid Services, or CMS, estimates that the total health care expenditures for Medicaid and the State Children's Health Insurance Program, or SCHIP, were $228.0 billion in 2001, $129.8 billion of which were federal funds, and $98.2 billion of which were state funds. CMS projects that total Medicaid and SCHIP outlays will reach $372.9 billion in fiscal year 2007.

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. SCHIP enrollment reached 4.6 million in 2001, a 38% increase over 2000 enrollment figures. CMS data indicates that by fiscal year 2007 total SCHIP outlays will be $5.0 billion.

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 and typically exceeds 50%. Federal payments for Medicaid have no set dollar ceiling and are only limited by the amount states are willing to spend. State and local governments pay the share of Medicaid costs not paid by the federal government.

Medicaid Managed Care. The Medicaid members we serve generally come from diverse cultures and ethnicities. Many have had limited education and do not speak English. Lack of adequate transportation is common.

Under traditional Medicaid programs, health care services are made available to low-income individuals in an uncoordinated manner. These individuals typically have minimal access to preventative care such as immunizations and access to primary care physicians, or PCPs, 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 incentives to monitor utilization and control costs.

In response, most states have implemented Medicaid managed care programs 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 is paid 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, and thereby strives 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, 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. According to information published by CMS, from 1996 to 2001, managed care enrollment among Medicaid beneficiaries has increased from 13.3 million to 20.8 million. All states in which we operate have mandated Medicaid managed care programs in place.

Our Competitive Advantages

We focus on serving low-income families and individuals who receive health care benefits through government-sponsored programs. We believe we are well positioned to capitalize on the growth opportunities in our market.

Experience. For 22 years we have focused on serving Medicaid beneficiaries as both a health plan and a provider through our clinics. 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, establish and maintain provider networks, and our administrative efficiency have allowed us to compete successfully for government contracts. We have a very strong track 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. These include centralized claims processing and information services which operate on 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 in new and existing markets.

Proven Expansion Capability. We have successfully developed and then replicated our business model. This has included the acquisition of health plans, the development of new operations and the transition of members from other plans. The establishment of our health plan in Utah reflected our ability to replicate our business model in new states, while the acquisitions in Michigan and Washington demonstrated our ability to acquire and successfully integrate existing health plan operations. For example, since our acquisition in Washington on December 31, 1999, membership increased from approximately 60,000 members to approximately 157,000 members as of September 30, 2002 while profitability also improved. Our plan is now the largest Medicaid managed care plan in the state. In Utah, our health plan is the largest Medicaid managed care plan in the state with 40,000 members as of September 30, 2002, an increase of 24,000 members during the nine month period then ended. Substantially all of the growth was from the successful integration of members from competing multi-product health plans which exited the market.

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 DRGs. Our provider network strategy is to contract with providers that are best suited, based on proximity, culture and experience, to provide services to a low-income population.

We operate 21 company-owned primary care clinics in California. These clinics require low capital expenditures, minimal start-up time and are profitable. 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 unique needs of our members, and a platform to pilot new programs.

Cultural and Linguistic Expertise. National census data shows that the population is becoming increasingly diverse. We have a 22-year history of developing targeted health care programs for our culturally diverse members and we believe we are well-positioned to successfully serve this growing population. 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 that are advised by our full-time cultural anthropologist. We educate employees and providers about the differing needs among 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 our experience as a provider has helped us improve medical outcomes for our members while resulting in cost savings. 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 a culturally diverse, low-income population. 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 low income families and individuals. To achieve this objective, we intend to:

Focus on serving low income families and individuals. We believe the Medicaid population, characterized by low income and significant ethnic diversity, requires unique services to meet its health care needs. Our 22 years of experience in serving this community has provided us significant expertise to successfully meet 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 from our centralized administrative infrastructure, 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 area and provider network, increasing awareness of the Molina brand name, and maintaining positive provider relationships.

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- *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 mandated Medicaid managed care enrollment.

Manage medical costs. We will continue to leverage our information systems, positive provider relationships and 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 particularly high cost needs and help limit the cost of their treatment.

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

Our Health Plans

Our health plans are located in California, Washington, Michigan and Utah. An overview of our health plans is outlined in the table below:

Summary of Health Plans as of September 30, 2002

State	Total Members	LTM Operating Revenue (1) (in thousands)	Number of Contracts	Expiration Date
California	252,000	$ 260,723	5	Varies between June 30, 2003 and December 31, 2004
Washington	157,000	$ 242,902	2	December 31, 2002(2)
Michigan	29,000	$ 48,425	1	October 1, 2004
Utah	40,000	$ 46,640	2	June 30, 2004 and June 30, 2006

(1) Includes premium and other operating revenue for the twelve months ended September 30, 2002.
(2) On December 16, 2002, our Washington health plan's contract was extended to December 31, 2003.

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 limited 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 Utah. Our contracts in Washington, Michigan and Utah have higher monthly payments but require us to cover more services. In California, providers of certain high cost services, such as specified organ transplants and pediatric oncology cases, are paid directly by the state. In Washington, the Social Security Income program retains financial responsibility for medical care provided to Medicaid beneficiaries that meet specific health and financial status qualifications. 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 has the third largest enrollment of Medicaid beneficiaries among non-governmental health plans in the state. 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. Acquired in December 1999 from Health Net, Inc., Molina Healthcare of Washington, Inc. is now the largest Medicaid managed health plan in the state. Our plan has grown from approximately 60,000 members at the time of the acquisition to approximately 157,000 members at September 30, 2002. We serve members in 27 of the state's 39 counties. Effective July 1, 2002, we acquired approximately 13,000 members in Washington in an assignment of contract from Aetna US Healthcare, Inc. for cash consideration.

Michigan. We originally acquired a minority investment in a Medicaid-only health plan exempt from HMO licensure requirements in 1998. In 1999 we purchased the remaining shares, and in 2000 we became licensed as an HMO under our subsidiary, Molina Healthcare of Michigan, Inc. We serve the metropolitan Detroit area, as well as nearly 30 other counties throughout Michigan. Effective October 1, 2002, we began serving approximately 6,000 additional members as a result of the exit of another plan from the market.

Utah. Molina Healthcare of Utah, Inc. is the largest Medicaid managed care health plan in Utah. We serve Salt Lake County as well as six other counties which collectively contain over 80% of the population in the state. Our Utah contract expires June 2004. Effective July 1, 2002, this contract was amended to provide us a one-year stop loss guarantee through June 30, 2003 for the first 40,000 members. Under the terms of the amendment, the state of Utah agreed to pay us 100% of medical costs plus 9% of medical costs as an administrative fee for providing medical and utilization management services. 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. The additional revenue we could receive is equal to the savings up to 5% of the predetermined amount plus 50% of the savings above 5% of that amount. For any members above 40,000, we have an executed memorandum of understanding with the state providing that the state will reimburse us for all medical costs associated with those members plus an administrative fee per member per month. Relative to the memorandum of understanding, there is no assurance we will enter into such a contract amendment or that its terms will be the same as the memorandum of understanding.

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 geographic areas, in specialties and with appropriate cultural and linguistic experience to meet the needs of our low-income members.

Physicians. We contract with PCPs, medical groups, specialists and independent practice associations, or IPAs. PCPs provide office-based primary care services. PCPs 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 PCP, 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 2001, the clinics had over 130,000 patient visits. These clinics are located in neighborhoods where our members reside, and provide us a first-hand opportunity to understand the special needs of our low-income members. The clinics assist us in developing and implementing community education, disease management and other programs before they are implemented throughout the company. The clinics also give us direct clinic management experience that enables us to better understand the needs of our independent physicians and groups.

Hospitals. We generally contract with hospitals that have significant experience dealing with the medical needs and administrative procedures of the Medicaid population. Under our plans, hospitals are reimbursed under a variety of payment methods, including fee-for-service, per diems, DRGs and case rates.

Medical Management

Our experience in medical management extends back to our roots as a provider organization. We utilize PCPs as the focal point of the delivery of health care to our members, providing routine and preventative 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. We develop specialized disease management programs that address the particular health care needs of our members. "*Motherhood Matters*" is a comprehensive program designed to improve pregnancy outcomes and enhance member satisfaction. "*Breathe with Ease*" 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 15. We anticipate that both of our programs will be fully implemented in all four states in which we operate.

Educational Programs. An important aspect of our approach to health care delivery is our educational programs. The programs are designed to increase awareness of various diseases, conditions and methods of prevention in a manner that supports the 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 PCPs, emergency rooms and nurse call centers.

Pharmacy Programs. Our pharmacy management program is focused on physician education and enforcing policies and procedures. Our pharmacists and physicians work with our pharmacy benefits manager to maintain a formulary that promotes generic drug use. We employ full-time pharmacists and pharmacy technicians who work with physicians to educate them on the use of specific drugs and how to best manage costs. This has resulted in a 99% generic utilization rate when a generic alternative is available in our drug formulary.

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 was proven by an independent third-party audit to be scalable to 11 million members. The software is flexible, easy to use and 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 which facilitates 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 dedicated staff which facilitates the development and implementation of a uniform, efficient and quality-based delivery model for health plan operations and coordinates and implements company-wide programs and strategic initiatives such as Health Plan Employer Data and Information Set, or HEDIS, and accreditation by the National Committee on Quality Assurance, or NCQA. The physicians in our network are credentialed using measures established by NCQA. We use peer review to routinely assess the quality of care rendered by providers.

Claims Processing. We pay at least 90% of properly billed claims within 30 days. Claims received electronically can be imported directly into the claims system, and many can be adjudicated automatically, thus eliminating the need for manual intervention. Most physician claims that are received in hard copy are scanned into electronic format and are processed by the claims system 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 for operations. 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, or HHS. Our uniform approach to compliance makes it easier for the health plans to share knowledge as it evolves and reduces the potential for compliance errors and any associated liability.

Competition

The Medicaid managed care industry is highly fragmented. According to CMS, as of June 30, 2001, there were over 500 Medicaid managed care contractors nationwide, including multi-product managed care organizations, or MCOs, Medicaid-only HMOs, prepaid health plans and primary care case management programs, or PCCMs. Below is a general description of our principal competitors for state contracts, members and providers:

- Multi-Product Managed Care Organizations—National and regional multi-product managed care organizations that have Medicaid members in addition to members in Medicare and private commercial plans.
- Medicaid HMOs—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 contracts, renewals of contracts, members and providers. To win a bid or to be awarded a contract, governments consider many factors, including, the plan’s provider network, medical management, responsiveness to member complaints, 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 offered, accessibility of services and reputation or name recognition. We believe factors that providers consider in deciding whether to contract with us include potential member volume, payment methods, timeliness and accuracy of claims payment and administrative service capabilities.

Regulation

Our health care operations 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, we must apply for and obtain a certificate of authority or license from the state. Our health plans are licensed to operate as HMOs in California, Washington, Michigan and Utah. In those jurisdictions, we are regulated by either the state insurance department or another state agency with responsibility for oversight of HMOs. The licensing requirements are the same for us as they are for health plans serving multi-product MCO members. We must demonstrate to the state that we have an adequate provider network, that our quality and utilization management processes comply with state requirements, and that we have a procedure in place for responding to member and provider complaints and grievances. We also must demonstrate that our

systems are capable of processing providers' claims in a timely fashion and for collecting and analyzing the information needed to manage our quality improvement activities. In addition, we must satisfy the state 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 regulatory agency in the state in which the health plan is licensed. They also undergo periodic examinations and reviews by the state. The plans generally must obtain approval from the state before declaring dividends in excess of certain thresholds. Each plan must maintain a net worth in an amount determined by statute or regulation and we may only invest in types of securities approved by the state. Any acquisition of another plan's members must also be approved by the state.

In addition, our Medicaid and SCHIP activities are regulated by each state's department of health services or equivalent agency. 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. It is state-operated and implemented, although it is funded by both the state and federal governments. 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 that can demonstrate it meets the state's requirements. Others, such as California, engage in a competitive bidding process. In either case, 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 have the capability 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 any risk of our insolvency.

Once awarded, our contracts generally have terms of one to six years, with renewal options at the discretion of the states. Our health plans are subject to periodic reporting and comprehensive quality assurance evaluations. We submit periodic utilization reports and other information to the state or county Medicaid program of our operations. 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.

To implement HIPAA, the federal government must adopt several final regulations. Although final regulations pertaining to privacy and electronic transactions have been adopted, security regulations and others have not yet been finalized. Moreover, the existing privacy regulations permit a state or any person to submit to the Secretary of the HHS a request to exempt a provision of state law from the impact of HIPAA.

We expect to achieve compliance with HIPAA by the applicable deadlines. However, given its complexity, the lack of final regulations in all necessary areas, the possibility that the regulations may change and may be subject to changing, and perhaps conflicting, interpretation, our ability to comply with all of the HIPAA requirements is uncertain. Further, due to the evolving nature of the HIPAA requirements we have not yet determined what our total compliance costs will be.

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 violation 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.

Properties

We lease a total of 35 facilities, including 21 medical clinics in California. We own a 37,000 square foot office building in Long Beach, California, which serves as our corporate headquarters.

Employees

As of September 30, 2002, we had approximately 795 full-time 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. Our employees are not represented by a union.

Legal Proceedings

We are involved in 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 financial position, results of operations, or cash flows.

MANAGEMENT

Our executive officers, key employees and directors, and their ages and positions are as follows:

Name	Age	Position
J. Mario Molina, M.D.	44	President & Chief Executive Officer; Chairman of the Board
John C. Molina, J.D.	38	Executive Vice President, Financial Affairs & Treasurer; Director
George S. Goldstein, Ph.D.	61	Executive Vice President, Health Plan Operations; Chief Executive Officer of Molina Healthcare of California; Director
Mark L. Andrews, Esq.	45	Executive Vice President, Legal Affairs, General Counsel and Corporate Secretary
M. Martha Bernadett, M.D.	39	Executive Vice President, Development
Harvey A. Fein	56	Vice President, Financial Affairs
Richard A. Helmer, M.D.	52	Vice President & Chief Medical Officer
David W. Erickson	47	Vice President, Information Services & Chief Information Officer
Ronna Romney (1)(2)(3)	59	Director
Ronald Lossett, CPA, D.B.A. (1)(2)(3)	60	Director
Charles Z. Fedak, CPA (1)(2)(3)	51	Director

(1) Member of the Audit Committee.
(2) Member of the Compensation Committee.
(3) Member of the Nominating Committee.

J. Mario Molina, M.D. has served as our President and Chief Executive Officer since succeeding his father and company founder, Dr. C. David Molina, in 1996. He has also served as our Chairman of the Board since 1996. Prior to that, he served as Medical Director from 1991 through 1994 and was our 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 and M. Martha Bernadett, M.D.

John C. Molina, J.D. has served as our Executive Vice President, Financial Affairs, and Treasurer since 1995 and our Treasurer since 2002. He also has served as a director since 1994. Mr. Molina has been employed by us for 22 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 J.D. from the University of Southern California School of Law. Mr. Molina is the brother of J. Mario Molina, M.D. and M. Martha Bernadett, M.D.

George S. Goldstein, Ph.D. has served as our Executive Vice President, Health Plan Operations and the Chief Executive Officer of Molina Healthcare of California since 1999 and has served as a director since 1998. Before joining us, Dr. Goldstein served as Chief Executive Officer of United Health Care 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. has served as our Executive Vice President, Legal Affairs, General Counsel and Corporate Secretary since 1998. He also has served as a member of the Executive Committee of our executive

officers since 1998. Before joining us, Mr. Andrews was a partner at Wilke, Fleury, Hoffelt, Gould & Birney of Sacramento, California from 1984 through 1997, where he chaired that firm's health care and employment law groups and represented us as outside counsel from 1994 through 1997. He earned a J.D. from Hastings College of the Law.

M. Martha Bernadett, M.D. has served as Executive Vice President, 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.

Harvey A. Fein has served as our Vice President, Financial Affairs, since 1995. Mr. Fein was Director of Corporate Finance at Blue Cross of California—WellPoint Health Networks, Inc. from 1990 to 1994. He earned an M.B.A. from the University of Wisconsin.

Richard A. Helmer, M.D. has served as our Vice President and Chief Medical Director since 2000. Dr. Helmer was an independent consultant from 1998 to 2000. He served as a medical director with FHP, Inc. from 1994 to 1998, and as a medical director for TakeCare, Inc. (the predecessor to FHP, Inc.) from 1992 to 1994.

David W. Erickson has served as our Vice President, Information Services and our Chief Information Officer since 1999. Prior to joining us, Mr. Erickson served as the Vice President and Chief Information Officer for United Health Care from 1997 to 1999, where he was responsible for information services for eight western states that cared for 3.5 million members.

Ronna Romney has served as a director since 1999 and also has served as a director of our Michigan health plan since 1999. She has served as a director for Park-Ohio Holding Corporation, a publicly traded logistics company, from 1999 to the present. Ms. Romney was a candidate for the United States Senate in 1996. She has published two books. From 1989 to 1993 she served as Chairperson of the President's Commission on White House Fellowships. From 1984 to 1992, Ms. Romney served as the Republican National Committeewoman for the state of Michigan, and from 1982 to 1985, she served as Commissioner of the Presidents' National Advisory Council on Adult Education.

Ronald Lossett, CPA, D.B.A. has served as a director since 2002. Mr. Lossett has served as a director of our California health plan since 1997. He was Chairman of the Board of Pacific Physician Services, Inc. and Chief Executive Officer prior to its merger with MedPartners, Inc. in 1996. Mr. Lossett is a certified public accountant.

Charles Z. Fedak, CPA has served as a director since 2002. Mr. Fedak founded Charles Z. Fedak & Co., Certified Public Accountants, in 1981. He was previously employed by KPMG Peat Marwick (formerly KPMG Main Hurdman) from 1975 to 1980. Mr. Fedak is a certified public accountant.

Board of Directors

We have a six member board of directors, three of whom are independent directors.

Board Committees

We have established an audit committee, a compensation committee and a nominating committee, each composed entirely of independent directors. The audit committee reviews our internal accounting procedures and reports to the board of directors with respect to other auditing and accounting matters, including the selection of our independent auditors, the scope of annual audits, fees and the performance of our independent auditors. The audit committee consists of Ronna Romney, Charles Z. Fedak and Ronald Lossett, the chair of the committee. The compensation committee reviews and recommends to the board of directors the salaries, benefits and stock option grants for our executive officers. The compensation committee also administers our stock option and other employee benefit plans. The compensation committee consists of Ms. Romney, Mr. Lossett and Mr. Fedak, the chair of the committee. The nominating committee nominates candidates for election to the board of directors. The nominating committee consists of Mr. Lossett, Mr. Fedak and Ms. Romney, the chair of the committee.

Classes Of Directors

We have approved a provision in our certificate of incorporation that will divide our board of directors into three classes effective upon the completion of this offering:

- Class I, whose term will expire at the annual meeting of the stockholders to be held in 2003,
- Class II, whose term will expire at the annual meeting of the stockholders to be held in 2004, and
- Class III, whose term will expire at the annual meeting of the stockholders to be held in 2005.

Our directors will designate a class for each director. At each of our annual stockholders' meetings following the completion of this offering, the successors to the directors whose terms will then expire will be elected to serve until the third annual stockholders' meeting after their election. Any additional directorships resulting from an increase in the number of directors will be distributed among the three classes so that, as nearly as possible, each class will consist of one-third of the directors. These provisions, when taken in conjunction with other provisions of our certificate of incorporation authorizing the board of directors to fill vacant directorships, may delay a stockholder from removing incumbent directors and simultaneously gaining control of the board of directors by filling the vacancies with its own nominees.

Agreements With Employees

We have entered into employment agreements with our Chief Executive Officer, J. Mario Molina, M.D., our Executive Vice President, Financial Affairs, and Treasurer, John C. Molina, J.D., our Executive Vice President, Legal Affairs, General Counsel and Corporate Secretary, Mark L. Andrews, our Executive Vice President, Health Plan Operations, George S. Goldstein, Ph.D., and our Executive Vice President, Development, M. Martha Bernadett, M.D.

The agreements each have an initial term with automatic one year extensions. The agreement with Dr. Molina has an initial term of three years which began on January 1, 2002, a base annual salary of $500,000 and a discretionary annual bonus of up to the lesser of $500,000 or 1% of our earnings before interest, taxes, depreciation and amortization for such year. The agreement with John C. Molina has an initial term of two years which began on January 1, 2002, a base annual salary of $400,000 and a discretionary annual bonus of up to 50% of his base annual salary. The agreement with Mark L. Andrews has an initial term of three years which began on December 1, 2001, a base annual salary of $323,400 and a discretionary annual bonus of up to 40% of his base annual salary. The agreement with Dr. Goldstein has an initial term of three years which began on December 1, 2001, a base annual salary of $358,400 and a discretionary bonus of up to 45% of his base annual salary. The agreement with Dr. Bernadett has an initial term of one year which began on January 1, 2002, a base annual salary of $300,000 and a discretionary bonus of up to 33% of her base annual salary.

These agreements provide for their continued employment for a period of two years following the occurrence of a change of control (as defined below) of our ownership. Under these agreements, each executive's terms and conditions of employment, including his rate of base salary, bonus opportunity, benefits and his title, position, duties and responsibilities, are not to be modified in a manner adverse to the executive following the change of control. If an eligible executive's employment is terminated by us without cause (as defined below) or is terminated by the executive for good reason (as defined below) within two years of a change of control, we will provide the executive with two times the executive's annual base salary and target bonus for the year of termination, full vesting of Section 401(k) employer contributions and stock options, and continued retirement, deferred compensation, health and welfare benefits for the earlier of three years or the date the executive receives substantially similar benefits from another employer. Additionally, if the executive's employment is terminated by us without cause or the executive resigns for good reason before a change of control, the executive will be entitled to receive one year's base salary, the target bonus for the year of the employment termination, full vesting of Section 401(k) employer contributions and stock options and continued retirement, deferred compensation, health and welfare benefits for the earlier of eighteen months or the date the executive receives substantially similar benefits from another employer. Payment of severance benefits is contingent upon the executive signing a release agreement waiving claims against us.

The agreements also ensure that an executive who receives severance benefits—whether or not in connection with a change in control—will also receive various benefits and payments otherwise earned by or owing to the executive for his prior service. Such an executive will receive a pro-rata target bonus for the year of his employment termination and payment of all accrued benefit obligations. We will also make additional payments to any eligible executive who incurs any excise taxes pursuant to the golden parachute provisions of the Internal Revenue Code in respect of the benefits and other payments provided under the agreement or otherwise on account of the change of control. The additional payments will be in an amount such that, after taking into account all applicable federal, state and local taxes applicable to such additional payments, the executive is able to retain from such additional payments an amount equal to the excise taxes that are imposed without regard to these additional payments.

A change of control generally means a merger or other change in corporate structure after which the majority of our stockholders are no longer stockholders, a sale of substantially all of our assets or our approved dissolution or liquidation. Cause is generally defined as the occurrence of one or more acts of unlawful actions involving moral turpitude or gross negligence or willful failure to perform duties or intentional breach of obligations under the employment. Good reason generally means the occurrence of one or more events that have an adverse effect on the executive's terms and conditions of employment, including any reduction in the executive's base salary, a material reduction of the executive's benefits or substantial diminution of the executive's incentive awards or fringe benefits, a material adverse change in the executive's position, duties, reporting relationship, responsibilities or status with us, the relocation of the executive's principal place of employment to a location more than 50 miles away from his prior place of employment or an uncured breach of the employment agreement. However, no reduction of salary or benefits will be good reason if the reduction applies to all executives proportionately.

The agreements with Dr. Molina, Mr. Molina, Mr. Andrews and Dr. Goldstein provide for each executive's right to require us to repurchase all shares of common stock acquired by such executive pursuant to the exercise of stock options upon their termination by us without cause or upon such executive terminating his employment agreement (i.e., a put right). These put rights are not exercisable for six months after the exercise of the stock options and expire upon the closing of this offering.

On November 7, 2002, we agreed to acquire fully vested stock options to purchase 640,000 shares and a related put option held by Dr. Goldstein. The put option permitted Dr. Goldstein to require us to purchase the 640,000 shares of stock underlying his options at their fair market value based on a methodology set forth in a previous employment agreement. These options were settled through a cash payment of $7,660,000 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 2002 fourth quarter compensation charge of $6,880,000.

On November 7, 2002, we agreed to acquire fully vested stock options to purchase 95,200 shares held by Mr. Andrews through a cash payment of $1,023,400. The cash payment was determined based on the negotiated fair value per share in excess of the 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 $915,500.

Except as discussed above, there are no other equity instruments issued by us whereby holders have a put right to require us to repurchase their shares at their election. In addition, we do not anticipate additional purchases of vested options or shares from other holders except for shares to be purchased through the stock redemption and by our contemplated employee stock ownership plan.

Compensation Of Directors

We pay each non-employee director an annual retainer of $18,000 and a $1,200 fee for each regularly scheduled board meeting attended in person. We pay the Chairman of the Audit Committee an additional annual retainer of $2,500.

We may, in our discretion, grant stock options and other equity awards to our non-employee directors from time to time under the 2002 Equity Incentive Plan, which is summarized below. The board may also decide to have automatic annual option grants under the 2002 Equity Incentive Plan.

Compensation Committee Interlocks And Insider Participation

No member of our compensation committee serves as a member of the board of directors or compensation committee of any entity, other than our health plans, that has one or more executive officers serving as a member of our board of directors or compensation committee. Ms. Ronna Romney serves on the board of directors of our Michigan health plan.

Executive Compensation

The following summary compensation table sets forth information concerning compensation earned in fiscal year 2001 by individuals who served as our Chief Executive Officer during 2001 and the remaining four most highly compensated executive officers as of December 31, 2001. We refer to these executives collectively as our named executive officers.

	Annual Compensation			Long-Term Compensation Awards		
Name And Principal Position	Salary ($)	Bonus ($)	Other Annual Compensation ($) (1)	Securities Underlying Options (#) (2)	Securities Underlying Options ($) (3)	All Other Compensation ($) (4)
J. Mario Molina, M.D. Chief Executive Officer, President, and Chairman	$400,000	$250,000	$ 7,200	—	$ —	$ 7,100(5)
John C. Molina, J.D. Executive Vice President, Financial Affairs, Treasurer and Director	250,272	175,000	7,200	—	—	7,013(6)
George S. Goldstein, Ph.D. Executive Vice President, Health Plan Operations and Director	327,691	116,969	7,300	160,000	1,206,240	8,647(7)
Mark L. Andrews, Esq. Executive Vice President, Legal Affairs, General Counsel and Corporate Secretary	287,290	80,400	7,250	72,000	542,808	7,037(8)
Richard A. Helmer, M.D. Vice President and Chief Medical Officer	286,788	4,943	7,200	57,120	430,628	7,494(9)

(1) Auto allowances
(2) Options granted to each named executive officer during 2001 to purchase the Company's common shares.
(3) Estimated fair value of the options on the date of grant.
(4) All other compensation includes employer matching contributions under the Company's 401(k) plan and the portion of premiums on life insurance benefits in excess of $50,000.
(5) 401(k) contributions of $6,800 and insurance premiums of $300.
(6) 401(k) contributions of $6,800 and insurance premiums of $213.
(7) 401(k) contributions of $6,800 and insurance premiums of $1,847.
(8) 401(k) contributions of $6,800 and insurance premiums of $237.
(9) 401(k) contributions of $6,800 and insurance premiums of $694.

Option Grants In Last Fiscal Year. The following table sets forth information regarding stock options granted during the fiscal year ended December 31, 2001 to our named executive officers. The amounts described in the following table under the heading "Potential Realizable Value at Assumed Annual Rates of Stock Price Appreciation for Option Term" represents hypothetical gains that could be achieved for the options if exercised at the end of the option term. These gains are based on assumed rates of stock value appreciation of 0%, 5% and 10% compounded annually from the date the options were granted until their expiration date. Actual gains, if any, on stock option exercises will depend on the future performance of the common stock and the date on which the options are exercised.

Option Grants in Year Ended December 31, 2001

Name	Number of Shares Underlying Options Granted	Percent of Total Options Granted to Employees in Fiscal Year	Exercise Price per Share	Expiration Date	Potential Realizable Value at Assumed Annual Rates of Stock Price Appreciation for Option Term (1)		
					0%	5%	.10%
J. Mario Molina, M.D.	—	—	$ —	—	$ —	$ —	$ —
John C. Molina, J.D.	—	—	—	—	—	—	—
George S. Goldstein, PhD.	160,000	42.3%	4.50	12/1/2011	900,000	1,919,000	3,482,000
Mark L. Andrews, Esq.	72,000	19.0%	4.50	12/1/2011	405,000	863,000	1,567,000
Richard A. Helmer, M.D.	57,120	15.1%	4.50	11/18/2011	321,000	685,000	1,243,000

(1) Calculated based on the estimated fair market value of $10.125 per share on the date of grant as determined by our board of directors based on comparable market values of similar companies and discounted cash flows valuation techniques.

Year-End Option Exercise and Option Value Table. The following table sets forth information concerning the number and value of unexercised options to purchase common stock held by the named executive officers. There was no public trading market for our common stock as of December 31, 2001. Accordingly, the values of the unexercised in-the-money options have been calculated on the basis of the estimated fair market value at that time of $10.125 per share, as determined by our board of directors, based on comparable market values of similar companies and discounted cash flows valuation techniques.

Aggregated Option Exercises In Last Fiscal Year
And Fiscal Year-End Option Values

Name	Number of Shares Acquired in Exercise	Value Realized	Number of Securities Underlying Unexercised Options at Fiscal Year-End		Value of Unexercised In-The-Money Options at Fiscal Year-End	
			Exercisable	Unexercisable	Exercisable	Unexercisable
J. Mario Molina, M.D.	—	$ —	—	—	$ —	$ —
John C. Molina, J.D.	—	—	—	—	—	—
George S. Goldstein, PhD.	—	—	680,000(1)	120,000	6,205,000	675,000
Mark L. Andrews, Esq.	—	—	200,000(2)	72,000	1,625,000	405,000
Richard A. Helmer, M.D.	—	—	—	57,120	—	321,300

(1) Options to purchase 640,000 shares were settled on November 7, 2002 through a cash payment of $7,660,000 resulting in a fourth quarter 2002 compensation charge of $6,880,000.
(2) Options to purchase 95,200 shares were settled on November 7, 2002 through a cash payment of $1,023,400, resulting in a fourth quarter 2002 compensation charge of $915,500.

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STOCK PLANS

2002 Equity Incentive Plan

The 2002 Equity Incentive Plan permits us to grant incentive stock options (within the meaning of Section 422 of the Internal Revenue Code), non-qualified stock options, restricted stock, performance shares and stock bonus awards to our officers, employees, directors, consultants, advisors and other service providers effective as of the offering date. The Equity Incentive Plan currently allows for the issuance of 1,600,000 shares of common stock, with a maximum of 600,000 of those shares eligible for issuance as restricted stock, performance shares and stock bonus awards. Beginning January 1, 2003, and upon each January 1st thereafter, the number of shares issuable under the Equity Incentive Plan will automatically increase by the lesser of 400,000 shares or 2% of our issued and outstanding capital stock on a fully-diluted basis, unless our board of directors otherwise determines to provide a smaller increase. Any shares reserved for issuance under the Omnibus Stock and Incentive Plan for Molina Healthcare, Inc. (as described below) that are not needed for outstanding options granted under that plan will be included in the shares reserved for the 2002 Equity Incentive Plan.

Our compensation committee administers the Equity Incentive Plan. Subject to the provisions of the Equity Incentive Plan, the compensation committee may select the individuals eligible to receive awards, determine the terms and conditions of the awards granted (including the number of shares or options to be awarded and the purchase price or exercise price, as the case may be), accelerate the vesting schedule of any award and generally administer and interpret the plan.

We intend to comply with the deductibility restrictions under Section 162(m) of the Internal Revenue Code of 1986, as amended. Stock option grants to our named executive officers after the end of the so-called reliance period for transition to public company status under United States Treasury regulations will have an exercise price at least equal to our common stock’s then fair market value, and the number of shares that may be subject to equity awards made during any one calendar year to a named executive officer shall not exceed 600,000.

Options are typically subject to vesting schedules, terminate ten years from the date of grant (five years in the case of incentive stock options granted to employees holding 10% or more of the voting power of Molina Healthcare, Inc., including any subsidiary corporations) and may be exercised for specified periods after the grantee terminates employment or other service relationship with us. The vesting date and service requirements of each award are determined by the compensation committee. The compensation committee may place additional conditions on equity awards such as the achievement of performance goals or objectives in a grant document.

Upon the exercise of options, the option exercise price must be paid in full either (i) in cash or by certified or bank check or other instrument acceptable to the compensation committee, or (ii) so long as it would not result in a financial charge against our earnings, by delivery of shares of common stock owned by the optionee for at least six months with a fair market value equal to the option exercise price or by a broker-assisted cashless exercise.

Restricted stock and performance shares may not be sold, assigned, transferred or pledged except as specifically provided in the grant document. If a restricted stock or performance share award recipient terminates employment or other services relationship with us or other events specified in the grant document occur, we have the right to repurchase some or all of the shares of stock subject to the award at the exercise price of such stock.

In the event of a change in control, the stock option agreements may provide for immediate accelerated vesting of any unvested shares as if the employee continued employment for another twelve months with additional accelerated vesting of any remaining unvested shares upon termination of the optionholder’s employment without cause or resignation by the optionholder for good reason within a year of the change in control. Notwithstanding the foregoing, we may require all outstanding awards to be exercised before the change

in control, terminate each outstanding award in exchange for a payment of cash and/or securities to the extent that such awards are vested, or terminate each outstanding award for no consideration to the extent that awards are unvested.

2000 Omnibus Stock and Incentive Plan

We have frozen any further grants of stock based compensation under the 2000 Omnibus Stock and Incentive Plan. As of September 30, 2002, stock options to purchase a total of 853,560 shares at a weighted average exercise price of $3.40 per share were outstanding under the Plan. On November 7, 2002, the options to purchase 95,200 shares granted under the Plan were settled with an executive through a cash payment of $1,023,400.

Other Options

Prior to the adoption of the 2000 Omnibus Stock and Incentive Plan, we granted options to an executive officer for the purchase of 640,000 shares at a weighted average exercise price of $0.78 per share. On November 7, 2002, the options to purchase 640,000 shares were settled through a cash payment of $7,660,000.

2002 Employee Stock Purchase Plan

Our 2002 Employee Stock Purchase Plan was adopted by our board of directors and approved by our stockholders in July 2002. The 2002 Employee Stock Purchase Plan is intended to qualify under Section 423 of the Internal Revenue Code and is administered by our compensation committee.

Up to 600,000 shares of common stock may be issued under the Employee Stock Purchase Plan, none of which have been issued as of the effective date of this offering. Beginning January 1, 2003, and upon each January 1st, thereafter, the number of shares issuable under the Employee Stock Purchase Plan will automatically increase by the lesser of 1% or 6,000 shares of our issued and outstanding capital stock on a fully-diluted basis.

The first offering under the Employee Stock Purchase Plan will begin on the effective date of this offering and end on June 30, 2003. Subsequent offerings will commence on each January 1 and July 1 thereafter and will have a duration of six months. Generally, all employees who are customarily employed for more than 20 hours per week as of the first day of the applicable offering period will be eligible to participate in the Employee Stock Purchase Plan. Any employee who first becomes eligible during an offering or is hired during an offering and otherwise meets the eligibility requirements will be eligible to participate in the offering on the first day of the offering period after the employee satisfies the eligibility requirements. An employee who owns or is deemed to own shares of stock representing in excess of 5% of the combined voting power of all classes of our stock (including the stock of any parent or subsidiary corporation) will not be eligible to participate in the Employee Stock Purchase Plan.

During each offering, an employee may purchase shares under the Employee Stock Purchase Plan by authorizing payroll deductions of up to 15% of his or her compensation during the offering period. Unless the employee has previously withdrawn from the offering, his or her accumulated payroll deductions will be used to purchase common stock on the last business day of each offering period at a price equal to 85% of the fair market value of the common stock on the first day of the offering period or, if later, the date on which the participant first begins participating in the offering or, or the last day of the offering period, whichever is lower. For purposes of the initial offering period, the fair market value of the common stock on the first day of the offering period will be the public offering price set forth on the cover page of the prospectus. Notwithstanding the foregoing, during the first purchase period of the initial offering period, all eligible employees will automatically be enrolled in the offering and will purchase shares of our common stock at the end of the first purchase period by making a lump sum cash payment equal to 10% of their compensation (unless an election is made, after the date of the initial offering period and prior to the end of the first purchase period, to commence payroll deduction or to withdraw from the Employee Stock Purchase Plan). Under applicable tax rules, an employee may purchase no more than $25,000 worth of common stock in any calendar year.

In the event of a change in control, we will accelerate the purchase date of the then current purchase period to a date immediately prior to the change in control, unless the acquiring or successor corporation assumes or replaces the purchase rights outstanding under the Employee Stock Purchase Plan. In the event of a proposed dissolution or liquidation of the Company, the current offering period will terminate immediately prior to the consummation of such event and we may either accelerate the purchase date of such purchase period to a date immediately prior to such event or return all accumulated payroll deductions to each participant, without interest.

401(k) Plan

We have established a 401(k) plan for our employees that is intended to be qualified under Section 401(k) of the Internal Revenue Code. Eligible employees are permitted to contribute to the 401(k) plan through payroll deduction within statutory and plan limits. The Company matches up to the first 4% of compensation contributed by employees. Upon the establishment of our employee stock ownership plan, we intend to discontinue the Company matching benefit provided to our employees in the 401(k) plan.

Employee Stock Ownership Plan and Trust

We intend to establish an employee stock ownership plan, ESOP, that will be qualified under Section 4975(e)(7) of the Internal Revenue Code. The ESOP will be intended to enable eligible employees to acquire ownership interests in our common stock. The ESOP will be administered by an independent trustee. We intend to borrow funds under our proposed credit facility and, in turn, loan the funds to the ESOP trustee for the purchase of approximately $20.0 million of our common stock prior to the closing of this offering from certain of our stockholders, including a trust, the remainder beneficiaries of which include directors and executive officers. The terms of the proposed credit facility, the loan to the ESOP trustee and the sale of shares of our common stock by certain stockholders to the ESOP trustee are not yet finalized.

Limitation Of Liability Of Directors And Indemnification Of Directors And Officers

As permitted by the Delaware General Corporation Law, or DGCL, our certificate of incorporation provides that our directors shall not be liable to us or our stockholders for monetary damages for breach of fiduciary duty as a director to the fullest extent permitted by the DGCL as it now exists or as it may be amended. As of the date of this prospectus, the DGCL permits limitations of liability for a director’s breach of fiduciary duty other than liability (i) for any breach of the director’s duty of loyalty to us or our stockholders, (ii) for acts or omissions not in good faith or which involve intentional misconduct or a knowing violation of law, (iii) under Section 174 of the DGCL, or (iv) for any transaction from which the director derived an improper personal benefit. Our bylaws provide that directors and officers shall be, and in the discretion of our board of directors, non-officer employees may be, indemnified by us to the fullest extent authorized by Delaware law, as it now exists or may in the future be amended, against all expenses and liabilities reasonably incurred in connection with service for or on our behalf. The bylaws also provide that the right of directors and officers to indemnification shall be a contract right and shall not be exclusive of any other right now possessed or hereafter acquired under any bylaw, agreement, vote of stockholders or otherwise. We also have directors’ and officers’ insurance against certain liabilities. This provision does not alter a director’s liability under the federal securities laws or to parties other than the Company or our stockholders and does not affect the availability of equitable remedies, such as an injunction or rescission, for breach of fiduciary duty.

Insofar as indemnification for liabilities arising under the Securities Act may be permitted to our directors, officers or controlling persons as described above, we have been advised that in the opinion of the Securities and Exchange Commission, or SEC, such indemnification is against public policy as expressed in the Securities Act and is therefore unenforceable.

RELATED PARTY TRANSACTIONS

Indemnification Agreements

We have entered into an indemnification agreement with each of our directors and officers. The indemnification agreement provides that the director or officer will be indemnified to the fullest extent not prohibited by law for claims arising in such person's capacity as a director or officer no later than 30 days after written demand to us. The agreement further provides that in the event of a change of control, we would seek legal advice from a special independent counsel selected by the officer or director and approved by us, who has not performed services for either party for five years, to determine the extent to which the officer or director would be entitled to an indemnity under applicable law. Also, in the event of a change of control or a potential change of control we would, at the officer's or director's request, establish a trust in an amount equal to all reasonable expenses anticipated in connection with investigating, preparing for and defending any claim. We believe that these agreements are necessary to attract and retain skilled management with experience relevant to our industry.

Option Settlements

On November 7, 2002, we agreed to acquire fully vested stock options to purchase 640,000 shares and a related put option held by Dr. Goldstein through a cash payment of $7,660,000. 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 2002 fourth quarter compensation charge of $6,880,000.

On November 7, 2002, we agreed to acquire fully vested stock options to purchase 95,200 shares held by Mr. Andrews through a cash payment of $1,023,400. The cash payment was determined based on the negotiated fair value per share in excess of the 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 $915,500.

Loans

We have made various loans to stockholders which are described below.

We have a note receivable from the Molina Family Trust (of which Mary R. Molina, mother of J. Mario Molina, M.D. and John C. Molina, J.D. is the trustee and beneficiary), secured by two medical buildings, bearing interest at 7% with monthly payments due through 2026. The balance at September 30, 2002 was $317,611.

We had a note receivable from the Molina Siblings Trust (of which John C. Molina, J.D. is the trustee and J. Mario Molina, M.D., M. Martha Bernadett, M.D., John C. Molina, J.D., Janet M. Watt and Josephine M. Battiste are the beneficiaries), secured by a medical building, bearing interest at 7% with monthly payments due through 2016. The balance at September 30, 2002 was $1,083,941, which was paid in full during the fourth quarter of 2002.

Under a $500,000 credit line, the Molina Siblings Trust owes us $387,852 at September 30, 2002, bearing interest at 7% and secured by 86,189 shares of our stock.

Facility Leases

Three medical center buildings are owned by members of the Molina family and are leased to us at rates equal to the average of the rates of our leases with third parties as a means of approximating fair market value. One of the leases expires in 2008 and has fixed annual rate increases. This lease has two 10-year renewal options. Two of the leases expire in 2007 and have rate increases every five years based on the Consumer Price Index. These leases have five remaining 5-year renewal options.

Services Contracts

We received architecture services from a firm in which a non-employee member of the Molina family was formerly a partner. We received technology services from a non-employee member of the Molina family. Both engagements have been concluded. Aggregate payments for these services for the nine months ended September 30, 2002 and the years ended December 31, 2001 and 2000 totaled $65,000, $130,000 and $18,000, respectively.

Split-Dollar Life Insurance

In 1997 and 2001, we agreed to make premium payments towards life insurance policies on the life of Mary R. Molina held by the Molina Siblings Trust in exchange for services from Mrs. Molina. We are entitled to receive repayment of all premium payments from the Molina Siblings Trust upon Mrs. Molina's death or earlier cancellation of the policy. Total receivables related to the premium payments, taking into account Mrs. Molina's life expectancy, is $1,282,420 as of September 30, 2002. Mrs. Molina no longer provides services as our employee or director.

Redemption of Stock

We intend to redeem approximately $20.0 million of our common stock using available cash reserves prior to the closing of this offering from certain of our stockholders, some of which are trusts, the remainder beneficiaries of which include directors and executive officers. The terms of the redemption are not yet finalized.

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PRINCIPAL STOCKHOLDERS

The following table sets forth information regarding the beneficial ownership of our common stock as of December 15, 2002 by:

- each person, entity or group known by us to own beneficially more than 5% of our outstanding common stock,
- each of our named executive officers and directors, and
- all of our executive officers and directors as a group.

Beneficial ownership is determined in accordance with the rules of the SEC. These rules generally attribute beneficial ownership of securities to persons who possess sole or shared voting power or investment power with respect to those securities and include shares of common stock issuable upon the exercise of stock options or warrants that are immediately exercisable or exercisable within 60 days. Shares of common stock subject to options currently exercisable or exercisable within 60 days are deemed outstanding for computing the percentage of the person holding these options but are not deemed outstanding for computing the percentage of any other person. Unless otherwise indicated, the persons or entities identified in this table have sole voting and investment power with respect to all shares shown as beneficially owned by them, subject to applicable community property laws. Unless otherwise indicated, the address of each of the named individuals is c/o Molina Healthcare, Inc., One Golden Shore Drive, Long Beach, California 90802.

Percentage ownership calculations are based on 20,000,000 shares outstanding as of December 15, 2002, which assumes the effectiveness of a forty-for-one stock split as a result of the exchange in the reincorporation merger prior to the effectiveness of this registration statement.

To the extent that any shares are issued on exercise of options, warrants or other rights to acquire shares of our capital stock that are presently outstanding or granted in the future, there will be further dilution to new public investors. The following table does not reflect the exercise of the over-allotment option.

Name	Number of Shares Beneficially Owned(1)	Percentage of Outstanding Shares
J. Mario Molina, M.D. (2)	660,373	3.3%
John C. Molina, J.D. (3)	6,838,177	34.2%
William Dentino (4)	11,853,819	59.3%
Curtis Pedersen (5)	10,322,457	51.6%
George S. Goldstein, Ph.D. (6)	160,000	*
Mark L. Andrews, Esq. (7)	176,000	*
Richard A. Helmer, M.D.(8)	57,120	*
Ronna Romney	—	—
Ronald Lossett, CPA, D.B.A.	—	—
Charles Z. Fedak, CPA	—	—
All executive officers and directors as a group (8 persons) (9)	8,655,573	43.3%

* Denotes less than 1%.

(1) As required by SEC regulation, the number of shares shown as beneficially owned includes shares which could be purchased within 60 days after December 15, 2002.

(2) Includes 645,692 shares owned by J. Mario Molina, M.D. as to which Dr. Molina has sole voting and investment power; and 14,681 shares owned by Dr. Molina and Therese A. Molina as community property as to which Dr. Molina has shared voting and investment power. Dr. Molina is a Director and our President and Chief Executive Officer.

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(3) Includes 426,029 shares owned by John C. Molina; 17,481 shares owned by Mr. Molina and Michelle A. Molina as community property as to which Mr. Molina has shared voting and investment power; 192,303 shares owned by the John C. Molina Trust (1995), of which Mr. Molina and Mr. Dentino are co-trustees with shared investment power and Mr. Molina is the beneficiary, and as to which Mr. Molina has sole voting power pursuant to a proxy; 62,933 shares owned by the Molina Children's Trust for John C. Molina (1997), of which Mr. Molina and Mr. Dentino are co-trustees with shared voting and investment power and Mr. Molina is the beneficiary; 3,356,000 shares owned by the Molina Siblings Trust, of which Mr. Molina is the trustee with sole voting and investment power and J. Mario Molina, M. Martha Bernadett, Josephine M. Battiste, Janet M. Watt and Mr. Molina are the beneficiaries; 1,114,419 shares owned by the MRM GRAT 301/2, of which Mr. Molina is the trustee with sole voting and investment power, Mary R. Molina is the income beneficiary and J. Mario Molina, M.D., John C. Molina, M. Martha Bernadett, M.D., Janet M. Watt and Josephine M. Battiste are the remainder beneficiaries; 1,193,451 shares owned by the MRM GRAT 301/3, of which Mr. Molina is the trustee with sole voting and investment power, Mrs. Molina is the income beneficiary and J. Mario Molina, M.D., John C. Molina, M. Martha Bernadett, M.D., Janet M. Watt and Josephine M. Battiste are the remainder beneficiaries; 425,167 shares owned by the MRM GRAT 502/2, of which Mr. Molina is the trustee with sole voting and investment power, Mrs. Molina is the income beneficiary and J. Mario Molina, M.D., John C. Molina, M. Martha Bernadett, M.D., Janet M. Watt and Josephine M. Battiste are the remainder beneficiaries; and 50,394 shares owned by the M/T Molina Children's Education Trust, of which Mr. Molina is the trustee with sole voting and investment power and J. Mario Molina's children are the beneficiaries. Mr. Molina is a Director and our Executive Vice President, Financial Affairs, and Treasurer.

(4) Includes 6,675,388 shares owned by the Mary R. Molina Living Trust, of which Mr. Dentino and Curtis Pedersen are co-trustees with shared voting and investment power, Mrs. Molina is the income beneficiary and J. Mario Molina, M.D., John C. Molina, M. Martha Bernadett, M.D., Janet M. Watt and Josephine M. Battiste are the remainder beneficiaries; 3,647,069 shares owned by the Molina Marital Trust, of which Mr. Dentino and Mr. Pedersen are co-trustees with shared voting and investment power, Mrs. Molina is the income beneficiary and J. Mario Molina, M.D., John C. Molina, M. Martha Bernadett, M.D., Janet M. Watt and Josephine M. Battiste are the remainder beneficiaries; 192,303 shares owned by the John C. Molina Trust (1995), of which Mr. Molina and Mr. Dentino are co-trustees with shared investment power and Mr. Molina is the beneficiary, and as to which Mr. Molina has sole voting power pursuant to a proxy; 192,303 shares owned by the Mary Martha Molina Trust (1995), of which Dr. Bernadett and Mr. Dentino are co-trustees with shared investment power and Dr. Bernadett is the beneficiary, as to which Dr. Bernadett has sole voting power pursuant to a proxy; 384,578 shares owned by the Janet M. Watt Trust (1995), of which Ms. Watt and Mr. Dentino are co-trustees with shared investment power and Ms. Watt is the beneficiary, as to which Ms. Watt has sole voting power pursuant to a proxy; 384,578 shares owned by the Josephine M. Molina Trust (1995), of which Ms. Battiste and Mr. Dentino are co-trustees with shared investment power and Ms. Battiste is the beneficiary, as to which Ms. Battiste has sole voting power pursuant to a proxy; 62,933 shares owned by the Molina Children's Trust for M. Martha Molina (1997) of which Mr. Dentino and M. Martha Bernadett, M.D. are co-trustees with shared voting and investment power and Dr. Bernadett is the beneficiary; 62,933 shares owned by the Molina Children's Trust for John C. Molina (1997), of which Mr. Molina and Mr. Dentino are co-trustees with shared voting and investment power and Mr. Molina is the beneficiary; 125,867 shares owned by the Molina Children's Trust for Janet M. Watt (1997), of which Mr. Dentino and Janet M. Watt are co-trustees with shared voting and investment power and Ms. Watt is the beneficiary; and 125,867 shares owned by the Molina Children's Trust for Josephine M. Molina (1997), of which Mr. Dentino and Josephine M. Battiste are co-trustees with shared voting and investment power and Ms. Battiste is the beneficiary. Mr. Dentino is counsel to Mary R. Molina, our former director and the mother of J. Mario Molina, M.D., John C. Molina and M. Martha Bernadett, M.D., and has provided legal services to various Molina family members and entities in which they have interests. His address is 555 Capitol Mall, Suite 1500, Sacramento, California 95814.

(5) Includes 6,675,388 shares owned by the Mary R. Molina Living Trust, of which Mr. Pedersen and Mr. Dentino are co-trustees with shared voting and investment power, Mrs. Molina is the income beneficiary and J. Mario Molina, M.D., John C. Molina, M. Martha Bernadett, M.D., Janet M. Watt and Josephine M. Battiste are the remainder beneficiaries; and 3,647, 069 shares owned by the Molina Marital Trust, of which Mr. Pedersen and Mr. Dentino are co-trustees with shared voting and investment power, Mrs. Molina is the income beneficiary and J. Mario Molina, M.D., John C. Molina, M. Martha Bernadett, M.D., Janet M. Watt and Josephine M. Battiste are the remainder beneficiaries. Mr. Pedersen is the uncle of J. Mario Molina, M.D., John C. Molina, J.D. and M. Martha Bernadett, M.D. Mr. Pedersen's address is 6218 East 6th Street, Long Beach, California 90803.

(6) Includes 160,000 shares which may be purchased pursuant to options. Dr. Goldstein is our Director and Executive Vice President, Health Plan Operations.

(7) Includes 176,800 shares which may be purchased pursuant to options. Mr. Andrews is our Executive Vice President, Legal Affairs, General Counsel and Corporate Secretary.

(8) Includes 57,120 shares which may be purchased pursuant to options. Dr. Helmer is our Vice President and Chief Medical Officer.

(9) Includes all shares beneficially owned or which may be purchased by J. Mario Molina, M.D., John C. Molina, J.D., George S. Goldstein, Ph.D., Mark L. Andrews, Esq., M. Martha Bernadett, M.D., Ronna Romney Ronald Lossett, CPA, D.B.A., and Charles Z. Fedak, CPA.

DESCRIPTION OF CAPITAL STOCK

On the completion of this offering, we will be authorized to issue 80,000,000 shares of common stock and 20,000,000 shares of preferred stock. Shares of each class have a par value of $0.001 per share. The following description summarizes information about our capital stock. You can obtain more comprehensive information about our capital stock by consulting our bylaws and certificate of incorporation, as well as the Delaware General Corporation Law.

Common Stock

As of September 30, 2002, our charter provided for one series of common stock, of which 500,000 shares were issued and outstanding and held of record by 46 shareholders. Each share of common stock will be exchanged for 40 shares of common stock upon our reincorporation in Delaware prior to the time we close this offering. Fractional shares will be rounded to the nearest whole share.

Each share of our common stock entitles the holder to one vote on all matters submitted to a vote of stockholders, including the election of directors. Subject to any preference rights of holders of preferred stock, the holders of common stock are entitled to receive dividends, if any, declared from time to time by the directors out of legally available funds. In the event of our liquidation, dissolution or winding up, the holders of common stock are entitled to share ratably in all assets remaining after the payment of liabilities, subject to any rights of holders of preferred stock to prior distribution.

The common stock has no preemptive or conversion rights or other subscription rights. There are no redemption or sinking fund provisions applicable to the common stock. All outstanding shares of common stock are fully paid and nonassessable and the shares of common stock to be issued on completion of this offering will be fully paid and nonassessable.

Preferred Stock

The board of directors has the authority, without action by the stockholders, to designate and issue preferred stock and to designate the rights, preferences and privileges of each series of preferred stock, which may be greater than the rights attached to the common stock. It is not possible to state the actual effect of the issuance of any shares of preferred stock on the rights of holders of common stock until the board of directors determines the specific rights attached to that preferred stock. The effects of issuing preferred stock could include one or more of the following:

- restricting dividends on the common stock,
- diluting the voting power of the common stock,
- impairing the liquidation rights of the common stock, or
- delaying or preventing a change of control of our company.

There are currently no shares of preferred stock outstanding.

There are currently no warrants outstanding.

Anti-Takeover Effects of Certain Provisions of Delaware Law and Molina’s Certificate of Incorporation and Bylaws

Some provisions of our certificate of incorporation and bylaws, may be deemed to have an anti-takeover effect and may delay or prevent a tender offer or takeover attempt that a stockholder might consider in one’s best interest, including those attempts that might result in a premium over the market price for the shares held by stockholders.

In connection with our reincorporation in Delaware, we increased the number of shares of common stock authorized for issuance to 80,000,000. The issuance of additional shares of common stock could have the effect of delaying, deferring or preventing a change of control, even if such change in control would be beneficial to our stockholders.

The terms of certain provisions of our certificate of incorporation and bylaws may have the effect of discouraging a change in control. Such provisions include the requirement that all stockholder action must be effected at a duly-called annual meeting or special meeting of the stockholders and the requirement that stockholders follow an advance notification procedure for stockholder business to be considered at any annual meeting of the stockholders.

Classified Board of Directors

Our board of directors is divided into three classes of directors serving staggered three-year terms. As a result, approximately one-third of the board of directors is elected each year. These provisions, when coupled with the provision of our certificate of incorporation authorizing the board of directors to fill vacant directorships or increase the size of the board of directors, may deter a stockholder from removing incumbent directors and simultaneously gaining control of the board of directors by filling the vacancies created by such removal with its own nominees.

Cumulative Voting

Under cumulative voting, a minority stockholder holding a sufficient percentage of a class of shares may be able to ensure the election of one or more directors. Our certificate of incorporation expressly denies stockholders the right to cumulative voting in the election of directors.

Advance Notice Requirements for Stockholder Proposals and Director Nominations

Our bylaws provide that stockholders seeking to bring business before an annual meeting of stockholders, or to nominate candidates for election as directors at an annual meeting of stockholders, must provide timely notice in writing. To be timely, a stockholder's notice must be delivered to or mailed and received at our principal executive offices not less than 90 days prior to the anniversary date of the immediately preceding annual meeting of stockholders. However, in the event that the annual meeting is called for a date that is not within 30 days before or after such anniversary date, notice by the stockholder in order to be timely must be received not later than the close of business on the 10th day following the date on which notice of the date of the annual meeting was mailed to stockholders or made public, whichever first occurs. Our bylaws also specify requirements as to the form and content of a stockholder's notice. These provisions may preclude, delay or discourage stockholders from bringing matters before an annual meeting of stockholders or from making nominations for directors at an annual meeting of stockholders.

Stockholder Action; Special Meeting of Stockholders

Our certificate of incorporation eliminates the ability of stockholders to act by written consent. It further provides that special meetings of our stockholders may be called only by our Chairman of the Board, Chief Executive Officer, President, a majority of our directors or committee of the board of directors specifically designated to call special meetings of stockholders. These provisions may limit the ability of stockholders to remove current management or approve transactions that stockholders may deem to be in their best interests and, therefore, could adversely affect the price of our common stock.

Authorized but Unissued Shares

Our authorized but unissued shares of common stock and preferred stock will be available for future issuance without stockholder approval. These additional shares may be utilized for a variety of corporate

purposes, including future public offerings to raise additional capital, corporate acquisitions and employee benefit plans. The existence of authorized but unissued shares of common stock and preferred stock could render more difficult or discourage an attempt to effect a change in our control or change in our management by means of a proxy contest, tender offer, merger or otherwise.

Charter Amendments

Delaware law provides generally that the affirmative vote of a majority of the shares entitled to vote on any matter is required to amend a corporation's certificate of incorporation or bylaws, unless either a corporation's certificate of incorporation or bylaws require a greater percentage.

Transfer Agent Registrar

The transfer agent and registrar for our common stock is   .

Listing

We have applied to list our common stock on the New York Stock Exchange under the symbol "MOH."

SHARES ELIGIBLE FOR FUTURE SALE

Prior to this offering, there has been no public market for our common stock, and we cannot predict the effect, if any, that market sales of shares or the availability of any shares for sale will have on the market price of the common stock prevailing from time to time. Sales of substantial amounts of common stock (including shares issued on the exercise of outstanding options and warrants), or the perception that such sales could occur, could adversely affect the market price of our common stock and our ability to raise capital through a future sale of our securities.

After this offering, shares of common stock will be outstanding, assuming the issuance of an aggregate of shares of common stock. The number of shares outstanding after this offering is based on the number of shares outstanding as of September 30, 2002 and assumes no exercise of outstanding options. The shares sold in this offering will be freely tradable without restriction under the Securities Act.

The remaining shares of common stock held by existing stockholders are restricted shares and are subject to the contractual restrictions described below. Restricted shares may be sold in the public market only if registered or if they qualify for an exception from registration under Rules 144 or 701 promulgated under the Securities Act, which are summarized below. All of these restricted shares will be available for resale in the public market in reliance on Rule 144 immediately following this offering and will be subject to lock-up agreements described below.

Sales of Restricted Shares and Shares Held by Our Affiliates

In general, under Rule 144 as currently in effect, an affiliate of the Company or a person, or persons whose shares are aggregated, who has beneficially owned restricted securities for at least one year, including the holding period of any prior owner except an affiliate of the Company, would be entitled to sell within any three month period a number of shares that does not exceed the greater of 1% of our then outstanding shares of common stock or the average weekly trading volume of our common stock on the New York Stock Exchange during the four calendar weeks preceding such sale. Sales under Rule 144 are also subject to certain manner of sale provisions, notice requirements and the availability of current public information about the Company. Any person, or persons whose shares are aggregated, who is not deemed to have been an affiliate of the Company at any time during the 90 days preceding a sale, and who has beneficially owned shares for at least two years including any period of ownership of preceding non-affiliated holders, would be entitled to sell such shares under Rule 144(k) without regard to the volume limitations, manner of sale provisions, public information requirements or notice requirements.

Subject to certain limitations on the aggregate offering price of a transaction and other conditions, Rule 701 may be relied upon with respect to the resale of securities originally purchased from the Company by its employees, directors, officers, consultants or advisors prior to the date the issuer becomes subject to the reporting requirements of the Exchange Act. To be eligible for resale under Rule 701, shares must have been issued in connection with written compensatory benefit plans or written contracts relating to the compensation of such persons. In addition, the SEC has indicated that Rule 701 will apply to typical stock options granted by an issuer before it becomes subject to the reporting requirements of the Exchange Act, along with the shares acquired upon exercise of such options, including exercises after the date of this offering. Securities issued in reliance on Rule 701 are restricted securities and, subject to the contractual restrictions described above, beginning 90 days after the date of this prospectus, may be sold by persons other than affiliates, subject only to the manner of sale provisions of Rule 144, and by affiliates, under Rule 144 without compliance with its one-year minimum holding period.

We have reserved an aggregate of 1,600,000 shares of common stock for issuance pursuant to our 2002 Equity Incentive Plan and options to purchase approximately 1,493,560 shares are outstanding at September 30, 2002 under the frozen Omnibus Stock and Incentive Plan and prior grants. On November 7, 2002, 735,200 of the

options were settled with two executives through cash payments of $8,683,400. We have also reserved an aggregate of 600,000 shares of common stock for issuance under our 2002 Employee Stock Purchase Plan.

As soon as practicable following the offering, we intend to file registration statements under the Securities Act to register shares of common stock reserved for issuance under the 2002 Equity Incentive Plan and the 2002 Employee Stock Purchase Plan as well as pre-IPO shares qualified under Rule 701 that may be issued under the 2000 Omnibus Stock and Incentive Plan. Such registration statement will automatically become effective immediately upon filing. Any shares issued upon the exercise of stock options or following purchase under the 2002 Employee Stock Purchase Plan will be eligible for immediate public sale, subject to the lock-up agreements noted below. See "Management — 2002 Equity Incentive Plan," "— 2000 Omnibus Stock and Incentive Plan" and "— 2002 Employee Stock Purchase Plan."

We have agreed not to sell or otherwise dispose of any shares of common stock during the 180-day period following the date of this prospectus, except we may issue, and grant options to purchase, shares of common stock under the 2002 Equity Incentive Plan and the 2002 Employee Stock Purchase Plan.

Lock-Up

Each of our executive officers, directors, stockholders and optionholders will have entered into lock-up agreements prior to the commencement of this offering providing, with limited exceptions, that they will not offer to sell, contract to sell or otherwise sell, dispose of, loan, pledge, or grant any rights with respect to any shares of common stock, any options or warrants to purchase, any of the shares of common stock or any securities convertible into, or exercisable or exchangeable for, common stock owned by them, or enter into any swap or other arrangement that transfers to another, in whole or in part, any of the economic consequences of ownership of the common stock, without the prior written consent of Banc of America Securities LLC and CIBC World Markets Corp., for a period of 180 days after the date of this prospectus.

Banc of America Securities LLC and CIBC World Markets Corp. in their sole discretion and at any time without notice, may release all or any portion of the securities subject to lock-up agreements. When determining whether or not to release shares from the lock-up agreements, Banc of America Securities LLC and CIBC World Markets Corp. will consider, among other factors, the stockholder's reasons for requesting the release, the number of shares for which the release is being requested and market conditions at the time. Following the expiration of the 180-day lock-up period, additional shares of common stock will be available for sale in the public market subject to compliance with Rule 144 or Rule 701.

UNDERWRITING

We are offering the shares of common stock described in this prospectus through a number of underwriters. Banc of America Securities LLC and CIBC World Markets Corp. are acting as joint book-running managers of the offering and together with SG Cowen Securities Corporation are acting as representatives of the underwriters. We have entered into a firm commitment underwriting agreement with the representatives. Subject to the terms and conditions of the underwriting agreement, we have agreed to sell to the underwriters, and each underwriter has agreed to purchase, at the public offering price less the underwriting discounts and commissions set forth on the cover page of this prospectus, the number of shares of common stock listed next to its name in the following table:

Underwriter	Number of Shares
Banc of America Securities LLC	
CIBC World Markets Corp.	
SG Cowen Securities Corporation	
Total	

The underwriters initially will offer shares to the public at the price specified on the cover page of this prospectus. The underwriters may allow some dealers a concession of not more than $ per share. The underwriters also may allow, and any dealers may re-allow, a concession of not more than $ per share to some other dealers. If all the shares are not sold at the initial public offering price, the underwriters may change the offering price and other selling terms. The common stock is offered subject to a number of conditions, including:

- receipt and acceptance of our common stock by the underwriters, and
- the right to reject orders in whole or in part.

The underwriters have an option to buy up to additional shares of common stock from us to cover sales of shares by the underwriters which exceed the number of shares specified in the table above at the public offering price less the underwriting discounts and commissions set forth on the cover page of this prospectus. The underwriters have 30 days from the date of this prospectus to exercise this option. If the underwriters exercise this option, they will each be obligated, subject to certain conditions, to purchase additional shares approximately in proportion to the amounts specified in the table above. If any additional shares of common stock are purchased, the underwriters will offer the additional shares on the same terms as those on which the shares are being offered. We will pay the expenses associated with the exercise of the over-allotment option.

The underwriting fee is equal to the public offering price per share of common stock less the amount paid by the underwriters to us per share of common stock. The underwriting fee is % of the initial public offering price. The following table shows the per share and total underwriting discounts and commissions to be paid to the underwriters assuming both no exercise and full exercise of the underwriters' option to purchase additional shares.

	Paid by Molina	
	No Exercise	Full Exercise
Per Share	$	$
Total	$	$

In addition, we estimate that our share of the total expenses of this offering, excluding underwriting discounts and commissions, will be approximately $.

We and our directors, executive officers, all of our existing stockholders and all of our optionholders will have entered into lock-up agreements with the underwriters prior to the commencement of this offering pursuant

to which we and such holders of stock and options have agreed, with limited exceptions, not to sell, directly or indirectly, any shares of common stock without the prior written consent of both Banc of America Securities LLC and CIBC World Markets Corp. for a period of 180 days after the date of this prospectus. This consent may be given at any time without public notice. We have entered into a similar agreement with the representatives of the underwriters, except that we may grant options and sell shares pursuant to our stock plans without such consent. There are no agreements between the representatives and any of our stockholders or affiliates releasing them from these lock-up agreements prior to the expiration of the 180-day period.

We have applied for listing on the New York Stock Exchange under the symbol “MOH.”

We will indemnify the underwriters against some specified types of liabilities, including liabilities under the Securities Act. If we are unable to provide this indemnification, we will contribute to payments the underwriters may be required to make in respect of those liabilities.

In connection with this offering, the underwriters may engage in stabilizing transactions, which involves making bids for, purchasing and selling shares of common stock in the open market for the purpose of preventing or retarding a decline in the market price of the common stock while this offering is in progress.

These stabilizing transactions may include making short sales of the common stock, which involves the sale by the underwriters of a greater number of shares of common stock than they are required to purchase in this offering, and purchasing shares of common stock on the open market to cover positions created by short sales. Short sales may be “covered” shorts, which are short positions in an amount not greater than the underwriters’ over-allotment option referred to above, or may be “naked” shorts, which are short positions in excess of that amount.

The underwriters may close out any covered short position either by exercising their over-allotment option, in whole or in part, or by purchasing shares in the open market. In making this determination, the underwriters will consider, among other things, the price of shares available for purchase in the open market compared to the price at which the underwriters may purchase shares through the over-allotment option.

A naked short position is more likely to be created if the underwriters are concerned that there may be downward pressure on the price of the common stock in the open market that could adversely affect investors who purchased in this offering. To the extent that the underwriters create a naked short position, they will purchase shares in the open market to cover the position.

The underwriters may also engage in other activities that stabilize, maintain or otherwise affect the price of the common stock, including the imposition of penalty bids. This means that if the representatives of the underwriters purchase common stock in the open market in stabilizing transactions or to cover short sales, the representatives can require the underwriters that sold those shares as part of this offering to repay the underwriting discount received by them.

As a result of these activities, the price of the common stock may be higher than the price that otherwise might exist in the open market. If the underwriters commence these activities, they may discontinue them at any time. The underwriters may carry out these transactions on the New York Stock Exchange, in the over-the-counter market or otherwise.

The underwriters do not expect sales to discretionary accounts to exceed 5% of the total number of shares of common stock offered by this prospectus.

Prior to this offering, there has been no public market for our common stock. The initial public offering price will be determined by negotiation between us and the representatives of the underwriters. Among the factors considered in these negotiations are:

- the history of, and prospects for, our company and the industry in which we compete,
- the past and present financial performance of our company,
- an assessment of our management,
- the present state of our development,
- the prospects for our future earnings,
- the prevailing market conditions of the applicable United States securities market at the time of this offering, market valuations of publicly traded companies that we and the representatives of the underwriters believe to be comparable to our company, and
- other factors deemed relevant.

The estimated initial public offering price range set forth on the cover of this preliminary prospectus is subject to change as a result of market conditions and other factors.

The underwriters, at our request, have reserved for sale to our employees, family members of employees, business associates and other third parties at the initial public offering price up to 5% of the shares being offered by this prospectus. The sale of these shares will be made by   . We do not know if our employees or affiliates will choose to purchase all or any portion of these reserved shares, but any purchases they do make will reduce the number of shares available to the general public. Reserved shares purchased by our employees and affiliates will not be subject to a lock-up except as may be required by the Conduct Rules of the National Association of Securities Dealers. These rules require that some purchasers of reserved shares be subject to three-month lock-ups if they are affiliated with or associated with NASD members or if they or members of their immediate families hold senior positions at financial institutions. If all of these reserved shares are not purchased, the underwriters will offer the remainder to the general public on the same terms as the other shares offered by this prospectus.

LEGAL MATTERS

The validity of the common stock offered by this prospectus will be passed upon for us by McDermott, Will & Emery, Los Angeles, California. Certain legal matters in connection with the offering will be passed upon for the underwriters by Willkie Farr & Gallagher, New York, New York.

EXPERTS

The consolidated financial statements of Molina Healthcare, Inc., at December 31, 2000 and 2001, and for the years then ended, appearing in this Prospectus and Registration Statement have been audited by Ernst & Young LLP, independent auditors, as set forth in their report thereon appearing elsewhere herein, and are included in reliance upon such report given on the authority of such firm as experts in accounting and auditing.

The consolidated financial statements of Molina Healthcare, Inc. (formerly, American Family Care, Inc.) for the year ended December 31, 1999 included in this prospectus have been audited by Deloitte & Touche LLP, independent auditors, as stated in their report appearing herein and have been so included in reliance upon the report of such firm given upon their authority as experts in accounting and auditing.

The statements of income and comprehensive income and cash flows of QualMed Washington Health Plan, Inc. for the year ended December 31, 1999, appearing in this Prospectus and Registration Statement have been audited by Ernst & Young LLP, independent auditors, as set forth in their report thereon appearing elsewhere herein, and are included in reliance upon such report given on the authority of such firm as experts in accounting and auditing.

WHERE YOU CAN FIND MORE INFORMATION

This prospectus constitutes a part of a registration statement on Form S-1 (together with all amendments, supplements, schedules and exhibits to the registration statement, referred to as the registration statement) which we have filed with the SEC under the Securities Act, with respect to the common stock offered in this prospectus. This prospectus does not contain all the information which is in the registration statement. Certain parts of the registration statement are omitted as allowed by the rules and regulations of the SEC. We refer you to the registration statement for further information about our company and the securities offered in this prospectus. Statements contained in this prospectus concerning the provisions of documents filed as exhibits are not necessarily complete, and reference is made to the copy so filed, each such statement being qualified in all respects by such reference. You can inspect and copy the registration statement and the reports and other information we file with the SEC at Room 1024, Judiciary Plaza, 450 Fifth Street, N.W., Washington, D.C. 20549. You can obtain information on the operation of the public reference room by calling the SEC at 1-800-SEC-0330. The same information will be available for inspection and copying at the regional offices of the SEC located at 233 Broadway, New York, New York 10279 and at Citicorp Center, 500 West Madison Street, Suite 1400, Chicago, Illinois 60661. You can also obtain copies of this material from the public reference room of the SEC at 450 Fifth Street, N.W., Washington, D.C. 20549, at prescribed rates. The SEC also maintains a Web site which provides on-line access to reports, proxy and information statements and other information regarding registrants that file electronically with the SEC at the address http://www.sec.gov.

Upon the effectiveness of the registration statement, we will become subject to the information requirements of the Exchange Act. We will then file reports, proxy statements and other information under the Exchange Act with the SEC. You can inspect and copy these reports and other information of our company at the locations set forth above or download these reports from the SEC’s website.

We have applied to have our common stock approved for quotation on the New York Stock Exchange.

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REPORT OF ERNST & YOUNG LLP, INDEPENDENT AUDITORS

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, 2000 and 2001, and the related consolidated statements of income, stockholders' equity and cash flows for the years then ended. 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 auditing standards generally accepted in the 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 as of December 31, 2000 and 2001, and the consolidated results of their operations and their cash flows for the years then ended, in conformity with accounting principles generally accepted in the United States.

Ernst & Young LLP

Los Angeles, California
March 29, 2002, except Note 10, as to
which the date is , 2003

The foregoing report is in the form that will be signed upon the completion of the restatement of capital accounts described in Note 10 to the consolidated financial statements.

/s/ ERNST & YOUNG LLP

Los Angeles, California
December 23, 2002

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REPORT OF DELOITTE & TOUCHE LLP, INDEPENDENT AUDITORS

The accompanying consolidated financial statements give effect to the consummation of a reincorporation and merger and related restatements of capital accounts, including the effects of a 40-for-1 stock split (the “Transaction”), which is expected to take place immediately prior to the effectiveness of the registration statement for the proposed offering of securities. The following report is in the form which will be furnished by Deloitte & Touche LLP upon consummation of the Transaction as described in Note 10 to the consolidated financial statements, assuming, that from April 21, 2000 to the date the Transaction is consummated, no other material events have occurred that would affect the accompanying consolidated financial statements or require disclosure therein.

“The Board of Directors and Stockholders
Molina Healthcare, Inc. (formerly, American Family Care, Inc.)

We have audited the accompanying consolidated financial statements of income, stockholders’ equity and cash flows of Molina Healthcare, Inc. (formerly, American Family Care, Inc.) and subsidiaries for the year ended December 31, 1999. These consolidated financial statements are the responsibility of the Company’s management. Our responsibility is to express an opinion on these consolidated financial statements based on our audit.

We conducted our audit in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from 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 audit provides a reasonable basis for our opinion.

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the consolidated results of operations and cash flows of Molina Healthcare, Inc. (formerly, American Family Care, Inc.) and subsidiaries for the year ended December 31, 1999, in conformity with accounting principles generally accepted in the United States of America.

As discussed in Note 10, in connection with its initial public offering of common stock, the accompanying consolidated financial statements have been restated to give retroactive effect to the consummation of a reincorporation and merger and related restatements of capital accounts, including the effects of a 40-for-1 stock split.

DELOITTE & TOUCHE LLP

Costa Mesa, California
April 21, 2000 (, 2003 as to Note 10)”

DELOITTE & TOUCHE LLP

Costa Mesa, California
December 23, 2002

MOLINA HEALTHCARE, INC.

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

	December 31		September 30
	2000	2001	2002
			(Unaudited)
ASSETS			
Current assets:			
Cash and cash equivalents	$ 45,785	$ 102,750	$ 130,601
Receivables	32,688	21,078	31,996
Deferred income taxes	913	1,561	1,616
Prepaid and other current assets	2,408	2,844	4,751
Total current assets	81,794	128,233	168,964
Property and equipment, net	9,931	9,637	10,687
Goodwill and intangible assets, net	4,136	4,768	6,813
Restricted investments	3,050	2,000	2,000
Deferred income taxes	1,156	1,477	3,208
Advances to related parties and other assets	1,945	3,505	4,320
Total assets	102,012	149,620	195,992
LIABILITIES AND STOCKHOLDERS' EQUITY			
Current liabilities:			
Medical claims and benefits payable	49,515	64,100	85,497
Accounts payable and accrued liabilities	9,361	10,903	10,575
Income taxes payable	2,609	4,087	3,231
Current maturities of note payable	47	51	54
Total current liabilities	61,532	79,141	99,357
Note payable, less current maturities	3,401	3,350	3,309
Other long-term liabilities	2,351	2,370	2,967
Minority interest	121	—	—
Total liabilities	67,405	84,861	105,633
Commitments and contingencies			
Stockholders' equity:			
Common stock, $0.001 par value; 80,000,000 shares authorized, 20,000,000 shares issued and outstanding	5	5	5
Preferred stock, $0.001 par value; 20,000,000 shares authorized, no shares issued and outstanding	—	—	—
Accumulated other comprehensive loss	(23)	—	—
Retained earnings	34,625	64,754	90,354
Total stockholders' equity	34,607	64,759	90,359
Total liabilities and stockholders' equity	102,012	149,620	195,992

See accompanying notes.

MOLINA HEALTHCARE, INC.

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

	Year ended December 31			Nine months ended September 30	
	1999	2000	2001	2001	2002
				(Unaudited)	
Revenue:					
Premium revenue	$ 181,929	$ 324,300	$ 499,471	$ 368,245	$ 465,716
Other operating revenue	2,358	1,971	1,402	1,138	1,484
Investment income	1,473	3,161	2,982	2,488	1,330
Total operating revenue	185,760	329,432	503,855	371,871	468,530
Expenses:					
Medical care costs:					
Medical services	73,990	107,883	149,999	110,594	130,492
Hospital and specialty services	55,200	127,139	212,799	156,638	214,895
Pharmacy	18,948	29,386	45,612	33,435	41,185
Total medical care costs	148,138	264,408	408,410	300,667	386,572
Marketing, general and administrative expenses	18,511	38,701	42,822	31,392	37,844
Depreciation and amortization	1,625	2,085	2,407	1,760	2,669
Total expenses	168,274	305,194	453,639	333,819	427,085
Operating income	17,486	24,238	50,216	38,052	41,445
Other income (expense):					
Interest expense	(138)	(578)	(347)	(263)	(213)
Other, net	(1,052)	381	(214)	(258)	(56)
Total other expense	(1,190)	(197)	(561)	(521)	(269)
Income before income taxes	16,296	24,041	49,655	37,531	41,176
Provision for income taxes	6,576	9,156	19,453	14,703	15,576
Income before minority interest	9,720	14,885	30,202	22,828	25,600
Minority interest	(267)	79	(73)	97	—
Net income	9,453	14,964	30,129	22,925	25,600
Net income per share:					
Basic	0.47	0.75	1.51	1.15	1.28
Diluted	0.47	0.73	1.46	1.11	1.24

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY
(dollars in thousands)

	Common Stock		Accumulated Other Comprehensive Loss	Retained Earnings	Total
	Outstanding	Amount			
Balance at January 1, 1999	4,000	$ 5	$ (18)	$11,208	$11,195
Comprehensive income (loss):					
Net income	—	—	—	9,453	9,453
Other comprehensive loss, net of tax:					
Unrealized loss on marketable securities	—	—	(2)	—	(2)
Comprehensive income (loss)	—	—	(2)	9,453	9,451
Effect of share exchange	19,996,000	—	—	—	—
Balance at December 31, 1999	20,000,000	5	(20)	20,661	20,646
Comprehensive income (loss):					
Net income	—	—	—	14,964	14,964
Other comprehensive loss, net of tax:					
Unrealized loss on marketable securities	—	—	(3)	—	(3)
Comprehensive income (loss)	—	—	(3)	14,964	14,961
Cash dividends declared	—	—	—	(1,000)	(1,000)
Balance at December 31, 2000	20,000,000	5	(23)	34,625	34,607
Comprehensive income:					
Net income	—	—	—	30,129	30,129
Other comprehensive income, net of tax:					
Realized loss on marketable securities	—	—	23	—	23
Comprehensive income	—	—	23	30,129	30,152
Balance at December 31, 2001	20,000,000	5	—	64,754	64,759
Net income (unaudited)	—	—	—	25,600	25,600
Balance at September 30, 2002 (unaudited)	20,000,000	5	—	90,354	90,359

See accompanying notes.

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MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF CASH FLOWS
(dollars in thousands)

	Year ended December 31			Nine months ended September 30	
	1999	2000	2001	2001	2002
				(Unaudited)	
Operating activities					
Net income	$ 9,453	$ 14,964	$ 30,129	$ 22,925	$ 25,600
Minority interest	267	(79)	73	(97)	—
Adjustments to reconcile net income to net cash provided by operating activities:					
Depreciation and amortization	1,625	2,085	2,407	1,760	2,669
Deferred income taxes	(629)	(64)	(969)	(749)	(1,786)
Loss on disposal of property and equipment	132	245	416	29	36
Stock-based compensation	275	401	505	301	553
Changes in operating assets and liabilities, net of acquisitions:					
Receivables	7,415	(14,805)	11,610	7,729	(10,918)
Claims receivable—FHS Subsidiary	—	12,012	—	—	—
Prepaid and other current assets	(6,167)	7,529	(436)	5	(1,907)
Medical claims and benefits payable	(1,919)	389	14,585	12,333	21,397
Accounts payable and accrued liabilities	3,517	(2,345)	1,554	2,513	(328)
Income taxes payable	1,092	1,269	1,478	9,730	(856)
Net cash provided by operating activities	15,061	21,601	61,352	56,479	34,460
Investing activities					
Proceeds from sale of marketable securities, net	—	1,938	—	—	—
Release of statutory deposits	—	—	1,050	1,050	—
Purchase of equipment	(5,520)	(1,758)	(2,105)	(1,890)	(2,550)
Other long-term liabilities	—	615	(486)	278	44
Advances to related parties and other assets	(269)	(695)	(1,537)	(1,658)	(815)
Net cash acquired (paid) in purchase transactions	6,276	—	(1,250)	—	(3,250)
Net cash provided by (used in) investing activities	487	100	(4,328)	(2,220)	(6,571)
Financing activities					
Cash dividends declared	—	(1,000)	—	—	—
Proceeds from issuance of notes payable	17,300	—	—	—	—
(Purchase) maturity of restricted investments	(12,918)	12,800	—	—	—
Principal payments on notes payable and capital lease obligations	(61)	(13,836)	(59)	(35)	(38)
Net cash provided by (used in) financing activities	4,321	(2,036)	(59)	(35)	(38)
Net increase in cash and cash equivalents	19,869	19,665	56,965	54,224	27,851
Cash and cash equivalents at beginning of period	6,251	26,120	45,785	45,785	102,750
Cash and cash equivalents at end of period	26,120	45,785	102,750	100,009	130,601

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF CASH FLOWS (continued)
(dollars in thousands)

	Year ended December 31			Nine months ended September 30	
	1999	2000	2001	2001	2002
				(Unaudited)	
Supplemental cash flow information					
Cash paid during the period for:					
Income taxes	$ 6,125	$ 7,950	$ 18,944	$ 5,500	$ 18,218
Interest	140	580	342	257	208
Supplemental schedule of non-cash investing and financing activities					
Details of businesses acquired in purchase transactions:					
Fair value of assets acquired	45,449		1,250		3,250
Invested capital from prior year (Michigan HMO)	(2,028)		—		—
Liabilities assumed	(36,116)		—		—
Cash paid	7,305		1,250		3,250
Cash acquired in purchase transactions	13,581				
Net cash acquired	6,276				

See accompanying notes.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
(dollars in thousands, except per share data)
December 31, 2001

1. The Reporting Entity

On May 26, 1999, Molina Healthcare, Inc. (formerly American Family Care, Inc., the Company) was formed to operate as the parent for Molina Healthcare of California, a health maintenance organization (HMO). In November 1999, the owners of Molina Healthcare of California exchanged their 4,000 shares for 20,000,000 shares of the Company. The Company became the sole shareholder of Molina Healthcare of California and the Company's consolidated financial statements give retroactive effect to the reorganization for all periods presented. On January 1, 2000, Molina Healthcare of Utah, Inc. became a wholly owned subsidiary of the Company through an ownership transfer from Molina Healthcare of California.

The Company's operations include Molina Healthcare of California (California HMO), Molina Healthcare of Utah, Inc. (Utah HMO), Molina Healthcare of Washington, Inc. (Washington HMO), and Molina Healthcare of Michigan, Inc. (Michigan HMO). The Company acquired the Washington HMO in December 1999 and a controlling interest in the Michigan HMO in 1999.

The consolidated financial statements and notes give effect to a 40-for-1 stock split of our outstanding common stock and recapitalization as a result of the share exchange in the reincorporation merger to occur prior to the effectiveness of our registration statement with the Securities and Exchange Commission (see Note 10. Restatement of Capital Accounts).

2. Significant Accounting Policies

Principles of Consolidation

The consolidated financial statements include the accounts of the Company and all majority owned subsidiaries. All significant intercompany transactions and balances have been eliminated in consolidation.

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 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. The Company is paid a per member per month fee for all contracted medical services based on the number of beneficiaries the Company has enrolled. 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. Medi-Cal/Medicaid revenues represented 98% of the Company's 1999, 2000 and 2001 premium revenue.

Through July 2000, the California HMO was a subcontractor with another HMO to provide comprehensive health care services to Medi-Cal beneficiaries located in Sacramento. The Company terminated its subcontract and received $2,000 as a settlement for amounts owed relating to prior periods. The settlement was recorded as a

change in estimate and increased premium revenue and income before income taxes for the year ended December 31, 2000.

Effective July 1, 2002, the Utah HMO agreed to provide medical and utilization management services to Utah Medicaid members through June 30, 2003 under a 1-year stop-loss guarantee for the first 40,000 members. The state of Utah agreed to pay the Utah HMO 100 percent of medical costs plus 9 percent of medical costs as an administrative fee. In addition, if the actual medical costs and administrative fee are less than a predetermined amount, the Utah HMO will receive all or a portion of the difference as additional revenue. The additional revenue is equal to the savings up to 5% of the predetermined amount plus 50% of the savings above 5% of that amount. The arrangement is subject to review and revision on or after April 1, 2003.

Medical Care Costs

The Company arranges to provide comprehensive medical care services to its members through its 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 clinics operated by the Company and fees to contracted providers under capitation and fee-for-service arrangements. Medical care costs are expensed in the period the Company is obligated to provide such services.

Under capitation contracts, the Company pays a fixed per member per month payment to the provider without regard to the frequency, extent or nature of the medical services actually furnished. Capitation contracts include provisions for certain noncapitated services for which the Company is liable. Certain arrangements also contain incentive programs based on service delivery, quality of care, utilization management and other criteria. Expenses related to these programs are recorded in the period in which the related services are dispensed.

Under fee-for-service arrangements, the Company retains the financial responsibility for medical care provided at discounted payment rates. Medical claims and benefits payable include claims reported as of the balance sheet date and estimated costs of medical care services rendered but not reported. Such estimates are developed using actuarial methods and are based on many variables, including utilization of health care services, historical data for payment patterns, cost trends, product mix, seasonality and other factors. The Company includes loss adjustment expenses in the recorded claims liability. The estimation methods and the resulting reserves are continually reviewed and updated, and any adjustments are reflected in current operations. The Company has also recorded reserves for estimated referral claims related to insolvent medical groups. Such losses are not expected to be significant.

The state of Washington’s Social Security Income, or SSI, program provides medical benefits to Medicaid beneficiaries that meet specific health and financial status qualifications. The Washington HMO assists assigned Medicaid members to qualify for SSI program benefits. When qualified, the state of Washington assumes responsibility on a retroactive basis for the cost of patient care. The Washington HMO then proceeds to recover hospital claims payments paid on behalf of the SSI member. Estimates for claims recoveries are reported as reductions of medical care costs and medical claims and benefits payable.

The Company purchases stop-loss insurance to cover unusually high costs of care when incurred beyond a predetermined annual amount per enrollee.

Marketable Securities

The Company accounts for 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.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

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 are available for use in current operations, they are classified as current assets without regard to the securities' contractual maturity dates. Marketable securities held by the Company consisted primarily of debt securities acquired with the purchase of the Washington HMO, which were sold in 2000. Certain equity securities held by the Company, which were immaterial, were written off in 2001. At December 31, 2001, the Company has no available-for-sale securities.

Restricted Investments

Pursuant to the regulations governing the Company's subsidiaries, the Company maintained statutory deposits with each state as follows:

	December 31		September 30
	2000	2001	2002
			(Unaudited)
California	$ 300	$ 300	$ 300
Utah	550	550	550
Michigan	1,000	1,000	1,000
Washington	200	150	150
Idaho	1,000	—	—
Total	3,050	2,000	2,000

The Washington HMO was required to maintain a statutory deposit of $1,000 with the state of Idaho pursuant to certain commercial business written prior to its acquisition by the Company. In 2001, the plan had no further operations in Idaho and the statutory deposit was released.

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, equipment and automobiles including assets under capital leases 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. The building is amortized over its estimated useful life of 31.5 years.

Goodwill and Intangible Assets

The excess of the purchase price over the fair value of net assets acquired has been allocated to goodwill and identifiable intangible assets. Goodwill and intangible assets are amortized on a straight-line basis over periods not exceeding 15 years, the expected periods to be benefited. Effective January 1, 2002, the Company ceased amortization of goodwill in accordance with the provisions of Statement of Financial Accounting Standards No. 142, *Goodwill and Other Intangible Assets.* Accumulated amortization totaled $490, $914 and $2,119 (unaudited) at December 31, 2000 and 2001 and September 30, 2002, respectively.

Long-Lived Asset Impairment

The Company reviews long-lived assets for impairment when events or changes in business conditions indicate that their carrying value may not be recovered. The Company considers assets to be impaired and writes them down to fair value if expected associated cash flows are less than the carrying amounts. Fair value is the present value of the associated cash flows. The Company has determined that no long-lived assets are impaired at December 31, 2001 and September 30, 2002.

Income Taxes

The Company accounts 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 the Company’s 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

The Washington HMO is not subject to state income taxes. The state of Washington assesses taxes based on premium revenue. Such taxes totaled $2,013 and $4,028 in 2000 and 2001, respectively, and are included in marketing, general and administrative expenses. Premium taxes for the nine months ended September 30, 2001 and 2002 were $3,008 and $3,686, respectively (unaudited).

Professional Liability Insurance

The Company carries medical malpractice insurance for health care services rendered through its clinics in California with claims-made coverage of $5,000 per occurrence and an annual aggregate limit of $10,000. The Company also carries claims-made managed care professional liability insurance for its HMO operations subject to coverage limit of $5,000 per occurrence and in aggregate for each policy year. Accruals for uninsured claims and claims incurred but not reported are estimated by independent actuaries and are included in other long-term liabilities.

Stock-Based Compensation

The Company accounts for stock-based compensation using the intrinsic-value method prescribed in Accounting Principles Board (APB) Opinion No. 25, *Accounting for Stock Issued to Employees*. Compensation cost for stock options, if any, is measured as the excess of the market price of the Company’s stock at the date of grant over the amount an employee must pay to acquire the stock. SFAS No. 123, *Accounting for Stock-Based Compensation*, established accounting and disclosure requirements using a fair-value-based method of accounting for stock-based employee compensation plans. The Company has adopted the disclosure requirements of SFAS No. 123.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

Earnings Per Share

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

	Year ended December 31			Nine months ended September 30	
	1999	2000	2001	2001	2002
				(Unaudited)	
Shares outstanding at the beginning of the period(1)	20,000,000	20,000,000	20,000,000	20,000,000	20,000,000
Weighted average number of shares issued (acquired)	—	—	—	—	—
Denominator for basic earnings per share	20,000,000	20,000,000	20,000,000	20,000,000	20,000,000
Dilutive effect of employee stock options(2)	173,000	376,000	572,000	561,000	720,000
Denominator for diluted earnings per share	20,173,000	20,376,000	20,572,000	20,561,000	20,720,000

(1) Adjusted to reflect the share exchange in 1999 (see Note 1. The Reporting Entity) and a 40-for-1 stock split of the outstanding shares as a result of the exchange in the reincorporation merger (see Note 10. Restatement of Capital Accounts).

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

Cash and Cash Equivalents

Cash and cash equivalents include cash, money market funds and certificates of deposit with a maturity of three months or less on the date of purchase.

Concentrations of Credit Risk

Financial instruments which potentially subject the Company to concentrations of credit risk consist primarily of cash and cash equivalents, receivables and restricted investments. The Company invests a substantial portion of its cash in the Cadre Liquid Asset Fund (CLAF), a portfolio of highly liquid money market securities. The CLAF is one of a series of funds managed by the Cadre Institutional Investors Trust (Trust), a Delaware business trust registered as an open-end management investment. Restricted investments are invested principally in certificates of deposit and treasury securities. Concentration of credit risk with respect to accounts receivable is limited due to payors consisting principally of the governments of each state in which the HMO subsidiaries operate.

Fair Value of Financial Instruments

The Company's consolidated balance sheets include the following financial instruments: cash and cash equivalents, receivables, marketable securities, trade accounts, medical claims and benefits payable, note 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.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

Risks and Uncertainties

The Company's profitability depends in large part on accurately predicting and effectively managing medical care costs. The Company continually reviews its premium and benefit structure to reflect its 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 any health plan's control and could adversely affect the Company's ability to accurately predict and effectively control medical care costs. Costs in excess of those anticipated could have a material adverse effect on the Company's financial condition, results of operations or cash flows.

Segment Information

The Company presents segment information externally the same way management uses financial data internally to make operating decisions and assess performance. Each of the Company's subsidiaries sells healthcare packages in the form of bundled managed care to Medicaid members. 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, the Company has one reportable segment.

New Accounting Pronouncements

In June 2001, the Financial Accounting Standards Board (FASB) issued SFAS No. 141, *Business Combinations*, and No. 142, *Goodwill and Other Intangible Assets*, effective for fiscal years beginning after December 15, 2001. Under the new rules, goodwill and intangible assets deemed to have indefinite lives will no longer be amortized but will be subject to annual impairment tests in accordance with the Statements. Other intangible assets will continue to be amortized over their useful lives. The Company applied the new rules on accounting for goodwill and other intangible assets beginning in the first quarter of 2002. The Company performed the required impairment tests of goodwill and indefinite lived intangible assets in 2002, and no impairment was identified.

The following table reflects the unaudited consolidated results adjusted as though the adoption of the SFAS No. 142 non-amortization of goodwill provision occurred as of the beginning of the years ended December 31, 1999, 2000 and 2001 and the nine month period ended September 30, 2001:

	Year ended December 31			Nine months ended September 30	
	1999	2000	2001	2001	2002
Net income:					
As reported	$ 9,453	$ 14,964	$ 30,129	$ 22,925	$ 25,600
Adjusted	9,625	15,263	30,428	23,150	
Basic earnings per share:					
As reported	0.47	0.75	1.51	1.15	1.28
Adjusted	0.48	0.76	1.52	1.16	
Diluted earnings per share:					
As reported	0.47	0.73	1.46	1.11	1.24
Adjusted	0.48	0.75	1.48	1.13	

In August 2001, the FASB issued SFAS No. 144, *Accounting for the Impairment or Disposal of Long-Lived Assets.* SFAS No. 144 supersedes SFAS No. 121, *Accounting for the Impairment of Long-Lived Assets and for*

Long-Lived Assets to be Disposed of, effective for fiscal years beginning after December 15, 2001. SFAS No. 144 applies to all long-lived assets (including discontinued operations) and consequently amends APB No. 30, *Reporting the Results of Operations — Reporting the Effects of Disposal of a Segment of a Business and Extraordinary, Unusual and Infrequently Occurring Events and Transactions.* SFAS No. 144 develops an accounting model for long-lived assets that are to be disposed of by sale and requires the measurement to be at the lower of book value or fair value, less the cost to sell the assets. Additionally, SFAS No. 144 expands the scope of discontinued operations to include all components of an entity with operations that (1) can be distinguished from the rest of the entity and (2) will be eliminated from the ongoing operations of the entity in a disposal transaction. The provisions of SFAS No. 144 did not have a significant impact on the financial position, operating results or cash flows following its adoption on January 1, 2002.

Unaudited Interim Financial Statements

The unaudited financial statements as of September 30, 2002 and for the nine-month periods ended September 30, 2001 and 2002 reflect all adjustments, consisting of normal recurring adjustments, needed to present fairly the financial results for these interim periods. The consolidated results of operations for the interim periods are not necessarily indicative of the results that may be expected for the entire year ending December 31, 2002.

Reclassifications

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

3. Acquisitions

Michigan HMO

Through April 1999, the Company held a 24.05% interest in Michigan Managed Care Providers, Inc. In May 1999, the Company acquired the remaining 75.95% interest and purchased a 62.5% interest in Good Health Michigan, Inc. for $45. Following the 1999 acquisitions, the companies were merged to form the Michigan HMO, with the California HMO owning an 81.13% interest in the combined companies. On October 30, 2001, the California HMO acquired the outstanding 18.87% minority interest for $350. The Company recorded total goodwill and intangible assets of $4,591 in connection with the Michigan acquisitions.

Washington HMO

On December 31, 1999, the Company purchased the capital stock of QualMed Washington Health Plan, Inc. (QualMed—a state licensed HMO) from Foundation Health Systems, Inc. (FHS) for $7,260. The acquisition was accounted for as a purchase transaction. The purchase price approximated the book value of the net assets acquired, which was equal to their fair value. Consequently, no goodwill was generated in this transaction. To complete the purchase, the Company and FHS entered into a Loss Portfolio Transfer and 100% Quota Share Reinsurance Agreement (Agreement) with an FHS insurance subsidiary (FHS Subsidiary) to transfer and assign the risk in effect during 1999 relating to the non-Medicaid lines of business. As part of the Agreement, the Company also paid $6,750 to the FHS Subsidiary to reinsure the risk for commercial contracts that continued in effect in 2000. The prospective reinsurance premium was recorded as a prepaid asset at December 31, 1999, and was charged to medical services in 2000. The Company also agreed to assume commercial claims liabilities estimated at approximately $12,000 at December 31, 1999, that, as part of the purchase transaction, was reinsured by the FHS Subsidiary. Pursuant to the Agreement, the Company recorded a corresponding reinsurance receivable from the FHS Subsidiary on the acquisition date. The operating results of the Washington HMO are included in the consolidated financial statements from the date of acquisition.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

On July 1, 2002, the Washington HMO paid $3,250 (unaudited) to another health plan for the assignment of a Medicaid contract. The assigned contract had a remaining term of 6 months on the acquisition date and was subsequently renewed for an additional 1-year period. The assignment was accounted for as a purchase transaction. The purchase price was allocated to member contracts, an intangible asset, and is being amortized over 18-months.

California HMO

In November 2001, the California HMO paid $900 to another health plan in consideration for the assignment of the Sacramento Medi-Cal contract. Under the contract, the Company will provide Medi-Cal HMO services to eligible members in Sacramento for an initial term of 13 months, with two one-year renewal options. The assignment was accounted for as a purchase transaction. The purchase price was allocated to member contracts, an intangible asset, and is being amortized over the initial 13-month contract period.

4. Property and Equipment

A summary of property and equipment is as follows:

	December 31		September 30
	2000	2001	2002
			(Unaudited)
Land	$ 3,000	$ 3,000	$ 3,000
Building and improvements	6,728	6,981	7,745
Furniture, equipment and automobiles	5,243	5,975	7,666
	14,971	15,956	18,411
Less accumulated depreciation and amortization	(5,040)	(6,319)	(7,724)
Property and equipment, net	9,931	9,637	10,687

5. Related Party Transactions

Advances to related parties are as follows:

	December 31		September 30
	2000	2001	2002
			(Unaudited)
Note receivable due from Molina Family Trust, secured by two medical buildings, bearing interest at 7% with monthly payments due through 2026.	$ 326	$ 321	$ 318
Note receivable due from Molina Siblings Trust, secured by a medical building, bearing interest at 7% with monthly payments due through 2016.	—	1,093	1,084
Loan to Molina Siblings Trust under a $500 credit line, secured by 86,189 shares of the Company's stock, bearing interest at 7% due in 2010.	—	392	388
Advances to Molina Siblings Trust (Trust) pursuant to a contractual obligation in connection with a split-dollar life insurance policy with the Trust as the beneficiary. The advances, which are discounted based on the insured's actuarial life, are payable to the Company at the earlier of the insured's death or cancellation of the policy.	938	878	1,282
	1,264	2,684	3,072

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

The Molina Family Trust has agreements with the Company to lease two medical clinics. These leases have five remaining 5-year renewal options. In May 2001, the Company entered into a similar agreement with the Molina Siblings Trust for the lease of another medical clinic. The lease is for seven years with two 10-year renewal options. Rental expense for these leases totaled $81, $108 and $295 for the years ended December 31, 1999, 2000 and 2001, respectively, and $180 and $274 for the nine months ended September 30, 2001 and 2002, respectively (unaudited). Minimum lease payments for the subsequent five years consist of the following approximate amounts at December 31, 2001: $399 in 2002; $413 in 2003; $428 in 2004; $341 in 2005; and $317 in 2006.

The Company received architecture and technology services from companies owned by non-employee members of the Molina family. Payments for architecture services received in the years ended December 31, 1999, 2000 and 2001, totaled $20, $18 and $71, respectively. Payment for technology services received during the year ended December 31, 2001, totaled $59. Payments for such services totaled $43 and $65 for the nine months ended September 30, 2001 and 2002, respectively (unaudited).

6. Note Payable

During 1999, the Company obtained borrowings totaling $17,300. $13,800 was due to First Professional Bank, which consisted of a variable rate note payable of $1,000 and a fixed rate loan of $12,800. The fixed rate borrowing was collateralized by a restricted certificate of deposit in the same amount. The remaining $3,500 was due to a bank for the purchase of the Company’s corporate office building, with a fixed interest of 8.58% per annum through October 1, 2004. Thereafter, the interest rate may be adjusted in accordance with the terms and conditions of the agreement. The note payable is due October 1, 2024, and is collateralized by the office building.

During 2000, the Company repaid the notes payable of $13,800 to First Professional Bank. $12,800 was repaid using the proceeds of the matured restricted certificate of deposit. At December 31, 2000 and 2001 and September 30, 2002, the outstanding mortgage payable was $3,448, $3,401 and $3,363 (unaudited), respectively.

Future payments on the note payable as of December 31, 2001, for the years ending December 31, is as follows:

2002	$	51
2003		55
2004		60
2005		66
2006		71
Thereafter		3,098
		3,401

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

7. Income Taxes

The provision for income taxes is as follows:

	Year ended December 31			Nine months ended September 30	
	1999	2000	2001	2001	2002
				(Unaudited)	
Current:					
Federal	$ 5,642	$ 7,481	$ 17,541	$ 13,275	$ 15,182
State	1,563	1,739	2,881	2,177	2,180
Total current	7,205	9,220	20,422	15,452	17,362
Deferred:					
Federal	(565)	21	(934)	(723)	(1,520)
State	(64)	(85)	(35)	(26)	(266)
Total deferred	(629)	(64)	(969)	(749)	(1,786)
	6,576	9,156	19,453	14,703	15,576

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

	Year ended December 31			Nine months ended September 30	
	1999	2000	2001	2001	2002
				(Unaudited)	
Taxes on income at statutory federal tax rate	$ 5,704	$ 8,414	$ 17,379	$ 13,136	$ 14,412
State income taxes, net of federal benefit	1,005	1,091	1,850	1,398	1,244
Nondeductible expenses	356	(226)	—	—	—
Nondeductible goodwill	59	104	104	79	—
Other	93	(227)	168	90	111
Change in valuation allowance	(641)	—	(48)	—	(191)
Reported income tax expense	6,576	9,156	19,453	14,703	15,576

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

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

	December 31		September 30
	2000	2001	2002
			(Unaudited)
Accrued expenses	$ 640	$ 368	$ 581
State taxes	508	975	863
Shared risk	(418)	75	163
Other, net	183	143	9
Deferred tax asset—current	913	1,561	1,616
Net operating losses	556	384	384
Depreciation and amortization	208	18	168
Deferred compensation	461	720	1,090
Other accrued medical costs	128	543	1,059
Other, net	42	3	507
	1,395	1,668	3,208
Valuation allowance	(239)	(191)	—
Deferred tax asset—long term	1,156	1,477	3,208
Net deferred income tax assets	2,069	3,038	4,824

At December 31, 2001, the Company had federal and state net operating loss carryforwards (NOLs) of approximately $1,012 and $2,253, respectively ($934 and $2,175, respectively at September 30, 2002 (unaudited)), which begin to expire in 2012 and 2007, respectively. The NOLs resulted from the acquisition of the Michigan entities in May 1999 that were merged to form the Michigan HMO. Because of the ownership change, the NOLs are subject to an annual limitation. Prior to 2002, a valuation allowance had been established against the deferred tax assets due to uncertainty over the realizability of these NOLs in the future. The valuation allowance was reduced during the nine-month period ended September 30, 2002, when it became more likely than not that the NOLs would be realized.

8. Employee Benefits

The Company sponsors a defined contribution 401(k) plan that covers substantially all full-time salaried and clerical employees of the Company and its subsidiaries. Eligible employees are permitted to contribute up to the maximum allowed by law. The Company matches up to the first 4% of compensation contributed by employees. Contributions to the plan totaled $489, $541 and $737 in the years ended December 31, 1999, 2000 and 2001, respectively, and $783 (unaudited) for the nine months ended September 30, 2002.

9. Commitments and Contingencies

Leases

The Company leases office space, clinics, equipment and automobiles, which expire at various dates through 2008. Future minimum lease payments by year and in the aggregate under all noncancelable operating leases (including related parties) consist of the following approximate amounts:

Year ending December 31	
2002	$ 3,283
2003	2,687
2004	2,280
2005	1,695
2006	1,351
Thereafter	276
	11,572

Rental expense related to these leases totaled $3,156, $3,777 and $4,239 for the years ended December 31, 1999, 2000, and 2001, respectively, and is included in marketing, general and administrative expenses. Rental expense for the nine months ended September 30, 2001 and 2002 was $3,216 and $3,626, respectively (unaudited).

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. Recently, government activity has increased with respect to investigations and allegations concerning possible violations of regulations by health care providers, which could result in significant fines and penalties, exclusion from participating in the Medi-Cal/Medicaid programs, as well as repayments of previously billed and collected revenues.

During 1998, the California Department of Health Services, or DHS, contended that letters sent to patients in San Bernardino and Riverside Counties notifying them of a pending Medi-Cal program change and the need to reselect their current health plan physician violated state and federal marketing laws and the health plan’s Medi-Cal contract. In October 1998, the California HMO agreed to pay a penalty to DHS and suspend enrollment and marketing activities for sixty days in San Bernardino and Riverside Counties. Shortly following resolution with DHS, the Office of Inspector General of the U.S. Department of Health and Human Services, or OIG, informed the California HMO that it also had jurisdiction over the matter. In December 2001, the California HMO resolved the matter with OIG by making a $600 payment to the U.S. Department of Health and Human Services and committed to maintain in place policies and procedures designed to ensure compliance with applicable state and federal laws and Medicaid program requirements.

The Company is involved in 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 the opinion of management and the Company’s counsel, have a material adverse effect on the Company’s financial position, results of operations, or cash flows.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

Employment Agreements

In December 2001 and January 2002, the Company entered into three-year employment agreements with two executives, subject to automatic one-year extensions thereafter. The agreements provide for annual base salaries of $823 in the aggregate plus a Target Bonus, as defined. If the executives are terminated without cause or if they resign for good reason before a Change of Control, as defined, the Company 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 two employees are terminated for cause, no further payments are due under the contracts.

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.

The Company had a previous employment agreement with another executive dated December 7, 1998. Under this agreement, the executive was awarded options to purchase 640,000 shares of the Company’s common stock, which vested over three years. The exercise price of these options was $0.78 per share. If the executive terminated his employment or was terminated without cause, a registration statement in connection with a public offering became effective or the Company had a sale of or change in ownership of 30% or more, collectively, a contingent event, the executive had the right to require the Company to purchase the 640,000 shares of stock underlying his options at their fair market value based on a methodology set forth in the agreement (Put Option).

On November 7, 2002, the Company agreed to acquire fully vested stock options to purchase 640,000 shares of our common stock and the related Put Option held by the 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 2002 fourth quarter compensation charge of $6,880.

On November 7, 2002, the Company agreed to acquire fully vested stock options to purchase 95,200 shares of our 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

The Company’s principal operations are conducted through the four HMOs operating in California, Washington, Michigan and Utah. The 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 their stockholders. To the extent the subsidiaries must comply with these regulations, they may not have the financial flexibility to transfer funds to the Company. The Company’s proportionate share of the net assets in these subsidiaries (after intercompany eliminations) which may not be transferrable in the form of loans, advances or cash dividends without the consent of the regulators was $14.5 million and $27.7 million at December 31, 2000 and 2001, respectively, and $29.6 million at September 30, 2002 (unaudited).

The National Association of Insurance Commissioners, or NAIC, 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 new HMO rules, which may vary from state to state, have been adopted by the Washington, Michigan and Utah HMOs in 2001. California has not yet adopted NAIC risk based capital requirements for HMOs and have not formally given notice of its intention to do so. The NAIC's HMO rules, if adopted by California, may increase the minimum capital required for that state.

As of September 30, 2002, our HMOs had aggregate statutory capital and surplus of approximately $75.1 million (unaudited), compared with the required minimum aggregate statutory capital and surplus requirements of approximately $29.6 million (unaudited). All of the Company's health plans were in compliance with the minimum capital requirements. The Company has the ability and commitment to provide additional working capital to each of the subsidiary health plans when necessary to ensure that total adjusted capital continually exceeds regulatory requirements.

10. Restatement of Capital Accounts

The stockholders of the Company voted on July 31, 2002 to approve a proposed reincorporation merger whereby the Company will merge with and reincorporate into a newly formed Delaware corporation as the surviving corporation. The reincorporation merger will take effect prior to the effectiveness of a registration statement to be filed with the Securities and Exchange Commission and these financial statements reflect the effect of a 40-for-1 split of the Company's outstanding common stock as a result of the share exchange in the reincorporation merger.

The Delaware corporation's 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. The rights, preferences and privileges of each series of preferred stock will be designated by the Company's board of directors at a future date, which may include dividend and liquidation preferences and redemption and voting rights.

11. Stock Options

The Company has made periodic grants of stock options to key employees. During 2000, the Company adopted the Omnibus Stock and Incentive Plan (the Plan). Pursuant to the Plan, the Company may 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 Plan limits the number of shares that can be granted in one year to 10% of the outstanding common shares at the inception of the year. The Plan also provides that if the employees desire to sell the common shares acquired through the awards, the Company shall have a first right of refusal to purchase such shares at fair value as determined by an independent appraisal. Upon an initial public offering or a change in control as defined, all awards shall vest immediately. Exercise price, vesting periods and option terms will be determined by the board of directors.

Options granted to date are exercisable at $0.78 to $4.50 per share, vest over 28 to 44 months and expire in 10 years. During the years ended December 31, 1999, 2000 and 2001, the Company issued options to purchase 350,040, 181,760 and 378,000 shares of its common stock with an estimated total fair value of $722, $313 and $2,850, respectively. No options were issued during the nine months ended September 30, 2002.

1,368,040 of the Company's outstanding options at December 31, 2001 were granted with exercise prices at below fair value. Compensation expense recognized in the consolidated statements of income in connection with

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

these options was $275, $401 and $505 during 1999, 2000 and 2001, respectively. Compensation expense for the nine months ended September 30, 2001 and 2002 was $303 and $553, respectively (unaudited).

The Company estimates that amortization of deferred stock-based compensation, based upon stock options outstanding at December 31, 2001 and scheduled vesting periods, will consist of the following approximate amounts:

Year ending December 31	
2002	$ 728
2003	666
2004	641
2005	103
	2,138

Upon an initial public offering or a change of control, as defined, the awards will be subject to immediate vesting. Compensation expense related to options granted which is otherwise deferred will be recorded in full upon the occurrence of such event.

Had compensation cost been determined based on the fair value of the options at the grant date and amortized over the option's vesting period, consistent with the method prescribed by SFAS No. 123, the Company's net income and earnings per share would have been decreased to the pro forma amounts indicated below:

	Year ended December 31			Nine months ended September 30	
	1999	2000	2001	2001	2002
				(Unaudited)	
Net income:					
As reported	$ 9,453	$ 14,964	$ 30,129	$ 22,925	$ 25,600
Pro forma	9,355	14,703	29,781	22,729	25,329
Basic earnings per share:					
As reported	0.47	0.75	1.51	1.15	1.28
Pro forma	0.47	0.74	1.49	1.14	1.27
Diluted earnings per share:					
As reported	0.47	0.73	1.46	1.11	1.24
Pro forma	0.46	0.72	1.45	1.11	1.22

The fair value of the options was estimated at the grant date using the Minimum Value option-pricing model with the following assumptions used: a risk-free interest rate of 6.35%, 6.13% and 5.54% in 1999, 2000 and 2001, respectively; dividend yield of 0% and expected option lives of 120 months.

The Minimum Value option-pricing model 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 the Company's 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.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

Stock option activity and related information is as follows:

	Year ended December 31						Nine Months ended September 30			
	1999		2000		2001		2001		2002	
	Options	Weighted Average Exercise Price	Options	Weighted Average Exercise Price	Options	Weighted Average Exercise Price	Options	Weighted Average Exercise Price	Options	Weighted Average Exercise Price
							(Unaudited)			
Outstanding at beginning of period	640,000	$ 0.78	990,040	$ 1.21	1,171,800	$ 1.61	1,171,800	$ 1.61	1,498,600	$ 2.28
Granted	350,040	2.00	181,760	3.75	378,000	4.50	44,440	4.50	—	—
Exercised	—	—	—	—	—	—	—	—	—	—
Forfeited	—	—	—	—	51,200	3.13	51,200	3.13	5,040	4.50
Outstanding at end of period	990,040	1.21	1,171,800	1.61	1,498,600	2.28	1,165,040	1.65	1,493,560	2.28
Exercisable at end of period	—	—	444,440	0.78	995,960	1.34	920,240	1.22	1,087,800	1.47
Weighted average per option fair value of options granted during the period		2.07		1.72		7.54		—		—

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

	Options Outstanding			Options Exercisable	
Range of Exercise Prices	Number Outstanding at December 31, 2001	Weighted-Average Remaining Contractual Life (Number of Months)	Weighted-Average Exercise Price	Number Exercisable at December 31, 2001	Weighted-Average Exercise Price
$0.78	640,000	83	$ 0.78	640,000	$ 0.78
2.00	350,040	94	2.00	300,040	2.00
3.13	47,760	100	3.13	15,920	3.13
4.50	460,800	117	4.50	40,000	4.50
0.78–4.50	1,498,600	97	2.28	995,960	1.34

	Options Outstanding			Options Exercisable	
Range of Exercise Prices	Number Outstanding at September 30, 2002	Weighted-Average Remaining Contractual Life (Number of Months)	Weighted-Average Exercise Price	Number Exercisable at September 30, 2002	Weighted-Average Exercise Price
$0.78	640,000	74	$ 0.78	640,000	$ 0.78
2.00	350,040	85	2.00	350,040	2.00
3.13	47,760	91	3.13	31,840	3.13
4.50	455,760	107	4.50	65,920	4.50
0.78–4.50	1,493,560	88	2.28	1,087,800	1.47

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

12. Condensed Financial Information of Registrant

At December 31, 2001, the restricted net assets of the Company's subsidiaries exceed 25 percent of total consolidated net assets. Following are the condensed balance sheets of the Registrant as of December 31, 2000 and 2001 and the statements of income and cash flows for the period from May 26, 1999 (date of incorporation) to December 31, 1999 and for each of the two years ended December 31, 2001.

Condensed Balance Sheets

	December 31	
	2000	2001
Assets		
Current assets:		
Cash and cash equivalents	$ 628	$ 3,314
Deferred income taxes	153	121
Due from affiliates	903	—
Prepaid and other current assets	533	917
Total current assets	2,217	4,352
Property and equipment, net	1,124	2,251
Investment in subsidiaries	37,015	64,115
Deferred income taxes	132	396
Advances to related parties and other assets	249	1,785
Total assets	40,737	72,899
Liabilities and stockholders' equity		
Current liabilities:		
Accounts payable and accrued liabilities	2,976	2,592
Income taxes payable	2,771	2,825
Due to affiliates	—	1,424
Total current liabilities	5,747	6,841
Other long-term liabilities	383	1,299
Total liabilities	6,130	8,140
Commitments and contingencies		
Stockholders' equity:		
Common stock, $0.001 par value; 80,000,000 shares authorized, 20,000,000 issued and outstanding	5	5
Preferred stock, $0.001 par value; 20,000,000 shares authorized, no shares issued and outstanding	—	—
Accumulated other comprehensive loss	(23)	—
Retained earnings	34,625	64,754
Total stockholders' equity	34,607	64,759
Total liabilities and stockholders' equity	40,737	72,899

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Condensed Statements of Income

	Period from May 26, 1999 to December 31	Year ended December 31	
	1999	2000	2001
Revenue:			
Management fees	$ —	$ 16,650	$ 24,817
Investment income	—	13	114
Total operating revenue	—	16,663	24,931
Expenses:			
Medical care costs	—	2,465	6,480
Marketing, general and administrative expenses	—	11,484	15,926
Depreciation and amortization	—	102	636
Total expenses	—	14,051	23,042
Operating income	—	2,612	1,889
Other expense, net	—	(185)	(339)
Income before income taxes and equity in net income of subsidiaries	—	2,427	1,550
Provision for income taxes	—	902	697
Net income before equity in net income of subsidiaries	—	1,525	853
Equity in net income of subsidiaries	8,156(1)	13,439	29,276
Net income	8,156	14,964	30,129

(1) Amount includes equity in net income of subsidiaries from May 26, 1999 (date of incorporation of the Registrant) to December 31, 1999.

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MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

Condensed Statements of Cash Flows

	Period from May 26, 1999 to December 31	Year ended December 31	
	1999	2000	2001
Operating activities			
Cash (used in) provided by operating activities	$ (6,750)	$ 5,666	$ 984
Investing activities			
Acquisition of QualMed Washington Health Plan, Inc.	(6,000)	—	—
Dividends from (capital contributions to) subsidiaries	12,800	(1,725)	2,200
Purchases of equipment	—	(1,226)	(1,763)
Changes in due to (from) affiliate	—	(903)	2,327
Change in other assets and liabilities	—	(234)	(1,062)
Net cash provided by (used in) investing activities	6,800	(4,088)	1,702
Financing activities			
Cash dividends declared	—	(1,000)	—
Net cash used in financing activities	—	(1,000)	—
Net increase in cash and cash equivalents	50	578	2,686
Cash and cash equivalents at beginning of period	—	50	628
Cash and cash equivalents at end of period	50	628	3,314
Supplemental schedule of non-cash investing and financing activities			
Details of businesses acquired in purchase transactions			
Fair value of net assets acquired	7,260	—	—
Liabilities assumed	(1,260)	—	—
Net cash paid	6,000	—	—
Transfer from Molina Healthcare of California(1)	12,493	—	—

(1) The Registrant was incorporated on May 26, 1999 to operate as the parent company of the healthcare subsidiaries. Upon incorporation, the common stock of Molina Healthcare of California was transferred to the Registrant.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

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. The 1999 condensed financial statements above present the operating results and cash flows of the Registrant from May 26, 1999. 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.

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, credentialling, 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 2000 and 2001 for these services totaled $16,650 and $24,817 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 1999, 2000 and 2001, the Registrant received dividends from its subsidiaries totaling $12,800, $0 and $5,900, respectively. Such amounts have been recorded as a reduction to the investments in the respective subsidiaries.

During 1999, 2000 and 2001, the Registrant made capital contributions to certain subsidiaries totaling $0, $1,725 and $3,700, respectively, primarily to comply with minimum net worth requirements. Such amounts have been recorded as an increase in investment in the respective subsidiaries.

Note D—Dividends to Stockholders

During 2000, the Registrant declared dividends of $1,000 to its stockholders.

REPORT OF ERNST & YOUNG LLP, INDEPENDENT AUDITORS

The Board of Directors
Molina Healthcare, Inc.

We have audited the accompanying statements of income and comprehensive income and cash flows of QualMed Washington Health Plan, Inc. (the Company) for the year ended December 31, 1999. These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on the financial statements based on our audit.

We conducted our audit in accordance with auditing standards generally accepted in the 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 audit provides a reasonable basis for our opinion.

In our opinion, the statements of income and comprehensive income and cash flows of the Company present fairly, in all material respects, the results of its operations and its cash flows for the year ended December 31, 1999, in conformity with accounting principles generally accepted in the United States.

/s/ ERNST & YOUNG LLP

Seattle, Washington
June 21, 2002

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QUALMED WASHINGTON HEALTH PLAN, INC.

STATEMENT OF INCOME AND COMPREHENSIVE INCOME
(dollars in thousands)

	Year Ended December 31, 1999
Revenue:	
Premium revenue	$ 85,019
Other operating revenue	438
Investment income	2,216
Total operating revenue	87,673
Expenses:	
Medical care costs	79,033
Marketing, general and administrative expenses	5,462
Expenses paid to related parties	2,468
Depreciation and amortization	636
Total expenses	87,599
Operating income	74
Other expenses:	
Net realized losses on sales of investments	(156)
Loss before income taxes	(82)
Income tax benefit	(123)
Net income	41
Other comprehensive loss:	
Unrealized loss on investments, net of tax of $50	(93)
Comprehensive loss	(52)

See accompanying notes.

QUALMED WASHINGTON HEALTH PLAN, INC.

STATEMENT OF CASH FLOWS
(dollars in thousands)

	Year ended December 31, 1999
Operating activities	
Net income	$ 41
Adjustments to reconcile net income to net cash used in operating activities:	
Deferred taxes	3,110
Depreciation and amortization	636
Loss on disposal of equipment	1
Net realized loss on sales of investments	156
Changes in operating assets and liabilities:	
Premium receivable, net	2,627
Interest and other receivables	(4,011)
Other assets	23
Accounts payable and accrued liabilities	(5,230)
Medical claims payable	(3,541)
Amounts due to related parties	(1,401)
Net cash used in operating activities	(7,589)
Investing activities	
Proceeds from sales or maturities of investments	15,659
Purchases of investments	(3,505)
Purchases of equipment	(34)
Net cash provided by investing activities	12,120
Financing activities	
Capital contribution from related party	3,000
Dividend paid to related party	(14,136)
Equity assigned to related party	(937)
Net cash used in financing activities	(12,073)
Net decrease in cash and cash equivalents	(7,542)
Cash and cash equivalents, beginning of year	18,704
Cash and cash equivalents, end of year	11,162

See accompanying notes.

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QUALMED WASHINGTON HEALTH PLAN, INC.

NOTES TO FINANCIAL STATEMENTS

December 31, 1999

1. The Reporting Entity

QualMed Washington Health Plan, Inc. (QualMed Washington) was a wholly owned subsidiary of QualMed, Inc., (QualMed) which in turn was a wholly owned subsidiary of Foundation Health Systems, Inc. (FHS). On December 31, 1999, QualMed Washington was purchased by American Family Care, Inc. (AFC). AFC subsequently changed its name to Molina Healthcare, Inc. (Molina) and changed the name of QualMed Washington to Molina Healthcare of Washington, Inc. (the Company). Molina has other wholly owned or majority owned subsidiaries located in California, Michigan, and Utah.

The Company is licensed as a health maintenance organization (HMO) by the State of Washington Office of the Insurance Commissioner (OIC), and primarily provides health insurance coverage to enrollees of the Washington State (the State) Medicaid programs. The Company also markets its health care programs to employer groups in Washington and Idaho. Premium revenue from Medicaid contracts represented 100% of premium revenue during 1999. As such, the loss of any contract or decrease in reimbursement or enrollment under the contracts could have a material adverse effect on the Company in future years. The Company contracts with independent hospitals and other providers to provide medical services to the enrollees.

2. Significant Accounting Policies

Basis of Presentation

In connection with the purchase of the Company from FHS, the Company entered into a reinsurance agreement with FH Assurance Company (FHAC), an FHS subsidiary, effective January 1, 1999. As part of the reinsurance agreement, the Company transferred and assigned all non-Medicaid related assets and liabilities of the Company (as specified in the reinsurance agreement) and the risk in effect during 1999 relating to the non-Medicaid lines of business to FHAC. Also, as part of the reinsurance agreement, Molina paid $6.8 million to FHAC to reinsure the risk for commercial contracts that continued in effect in 2000. The premium was contributed by Molina to the Company and recorded as a prepaid asset. As a result, the accompanying statement of cash flows is shown net of the assets and liabilities transferred and assigned to FHAC under the reinsurance agreement. Such amounts included assets of $11.8 million and liabilities of $10.9 million. In addition, premium revenue, medical care costs, and administrative expenses reflect only those revenues and expenses attributable to the Medicaid products. Therefore, commercial premium revenue of $131.1 million, commercial medical care costs of $112.3 million, and administrative expenses of $18 million attributable to the commercial line of business have been excluded from the statements of income and comprehensive income and cash flows. Where certain general and administrative expenses were not specifically identified by line of business, those expenses were allocated based on the Company’s membership.

Premium Revenue

Premium revenue was recognized in the month in which the related enrollees were entitled to health care services.

Investment Income

Premiums and discounts on fixed income securities were recognized as adjustments to investment income, and amortized over the period to maturity. Interest on fixed-income securities was recognized in income as accrued. Gains or losses on the sale of fixed income securities were determined using the specific identification method. Proceeds from the sales of bonds totaled $10.2 million for 1999. Gross gains and losses on sales were $4,000 and $160,000, respectively, for 1999.

QUALMED WASHINGTON HEALTH PLAN, INC.

NOTES TO FINANCIAL STATEMENTS (Continued)

Medical Care Costs

Medical care costs were accrued in the period services were provided to the enrolled members, including an estimate for expenses incurred but not reported. Medical and hospital expenses included payments to primary care physicians, specialists, hospitals, pharmacies and other health care providers under fee-for-service and capitation arrangements.

The Company has capitation contracts with medical groups (Capitated Providers) to provide health care services to enrollees in their respective service areas for a fixed monthly amount. The Capitated Providers are at risk for the cost of medical care services provided to the Company's enrollees in the relevant geographic areas; however, the Company may be responsible for the provision of services to its enrollees should the Capitated Providers be unable to provide the contracted services. Medical care costs relating to these Capitated Providers amounted to $20.1 million for 1999.

The State's Social Security Income (SSI) program provides medical benefits to Medicaid beneficiaries who meet specific health and financial status qualifications. The Company assists assigned Medicaid members to qualify for SSI program benefits. When qualified, the State assumes responsibility on a retroactive basis for the cost of patient care. The Company then proceeds to recover hospital claims payments paid on behalf of the SSI member. Estimates for claims recoveries are reported as reductions of medical care costs.

Depreciation

Depreciation is calculated using the straight-line method based on the estimated useful lives of the related assets. Estimated useful lives range principally from three to seven years. Depreciation expense totaled $636,000 for 1999.

Reinsurance

Reinsurance premiums and claims are accounted for based on the terms of the reinsurance contract. Premiums earned and claims incurred are reported net of reinsured amounts. The Company remains obligated in the event that the reinsurer does not meet their obligations.

Taxes Based on Premiums

The states of Washington and Idaho require the remittance of premium taxes. These amounts are recorded in administrative expenses and totaled $1.6 million for 1999.

Risks and Uncertainties

The Company's profitability depends in large part on accurately predicting and effectively managing health benefits expense. The Company continually reviews its premium and benefit structure to reflect its underlying claims experience and revised actuarial data; however, several factors could adversely affect the health benefits expense. These factors, which include changes in health care practices, inflation, new technologies, major epidemics, natural disasters and malpractice litigation, are beyond any health plan's control and could adversely affect the Company's ability to accurately predict and effectively control health care costs. Costs in excess of those anticipated could have a material adverse effect on the Company's financial condition, results of operations or cash flows.

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QUALMED WASHINGTON HEALTH PLAN, INC.

NOTES TO FINANCIAL STATEMENTS (Continued)

Statement of Cash Flows

Cash and cash equivalents consist of all highly liquid investments with maturity of 90 days or less when purchased.

Use of Estimates

The preparation of financial statements in conformity with accounting practices generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

3. Related-Party Transactions

The Company incurred corporate cost allocations from QualMed of $1.3 million in 1999. The corporate allocation, which was based on a written agreement, was a systematic allocation of expenses paid by QualMed to support the operations of their subsidiaries.

The Company incurred regional cost allocations from QualMed and its affiliates totaling $1.1 million in 1999. These allocations relate to the respective companies' employees performing services for the Company.

The Company administered services for point-of-service product members under an agreement with Foundation Health Systems Life and Health Company (FHSL&H), a wholly owned affiliate of FHS. The Company received an administration fee for those services, which totaled $438,000 in 1999.

The Company purchased reinsurance from FHSL&H primarily for hospital costs. Reinsurance premiums of $147,000 for 1999 were included as an increase in medical care costs. Reinsurance recoveries under such contracts of $137,000 for 1999 was included as a reduction of medical care costs. Additionally, in conjunction with the sale of the Company to Molina, the Company incurred reinsurance premiums of $131.1 million and recognized recoveries of $112.3 million for 1999, which were ceded to FHAC in accordance with the reinsurance agreement.

The Company received a capital contribution from QualMed totaling $3.0 million and paid a dividend to QualMed totaling $14.1 million in 1999.

The Company utilized a wholly owned subsidiary of FHS as the Company's pharmacy benefits administrator. The affiliate earned an administrative fee based upon a fixed rate per member per month. Administrative fees incurred by the Company totaled $37,000 in 1999.

4. Income Taxes

The results of the Company's 1999 operations were included in FHS' consolidated federal income tax return. Pursuant to a tax allocation agreement with FHS, the Company reflected a provision for income taxes as if it were to file a separate federal income tax return. In fiscal years in which the Company incurred net losses for FHS consolidated purposes, FHS allocated a tax benefit to the Company based on an applicable tax rate. These amounts were settled with FHS via intercompany accounts. In connection with Molina's purchase of the Company from FHS, all deferred tax assets and liabilities and the non-Medicaid related tax provision were assigned to FHAC. Prior to assignment, the tax expense was $381,000, of which a tax benefit of $123,000 remained with the Company.

QUALMED WASHINGTON HEALTH PLAN, INC.

NOTES TO FINANCIAL STATEMENTS (Continued)

5. Employee Benefits

During 1999, employees of the Company were eligible to participate in FHS' 401(k) plan. Contribution expense totaled $127,000 for 1999.

6. Commitments and Contingencies

The Company is involved in various legal proceedings, which are routine to its business. The opinion of management, based upon current facts and circumstances known by the Company, is that the resolution of these matters should not have a material adverse effect on the financial position, results of operations, or cash flows of the Company. As a condition of the sale described in Note 1, the Company and Molina have been indemnified by FHS regarding legal proceedings arising out of events occurring prior to the date of the sale.

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. Recently, government activity has increased with respect to investigations and allegations concerning possible violations of regulations by health care providers, which could result in significant fines and penalties, exclusion from participating in the Medicaid programs, as well as repayments of previously billed and collected revenues.

The Company has been involved in disputes and litigation initiated by healthcare providers alleging non-payment or underpayment for services provided to plan members. The Company evaluated its exposure to such disputes and litigation as of December 31, 1999 for estimated losses at $2.4 million. The expenses arising out of events occurring before the sale described in Note 1 are covered under the reinsurance agreement. As such, the entire estimated liability and related expense has been assigned to FHA under the reinsurance agreement and is not included in the accompanying statement of income and comprehensive income for 1999.

The Company leases office facilities and equipment under noncancelable operating leases. Some of the leases contain renewal options through 2005. Rent expense related to these leases was $429,000 for 1999.

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[BACK COVER: COVER ART]

[Artwork in twelve colors depicting a health care provider and child holding a toy on a path which winds through a hillside and two people playing ball in the background on the hillside. Caption below reads: “Offering healthcare to families in need for over 20 years.” Below caption is Molina’s logo.]

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Shares

Common Stock

PROSPECTUS

, 2003

Joint Book-Running Managers

Banc of America Securities LLC **CIBC World Markets**

SG Cowen

Until , 2003, all dealers that buy, sell or trade the common stock may be required to deliver a prospectus, regardless of whether they are participating in the offering. This is in addition to the dealers' obligation to deliver a prospectus when acting as underwriters and with respect to their unsold allotments or subscriptions.

PART II INFORMATION NOT REQUIRED IN PROSPECTUS

Other Expenses of Issuance and Distribution

Following is our estimate of expenses of the offering, all of which shall be paid by us:

SEC Registration Fees	$10,580
NASD Fees	12,000
NYSE Fees	*
Accounting Fees and Costs	*
Legal Fees and Costs	*
Printing Costs	*
Transfer Agent Fees and Costs	*
Blue Sky Fees and Costs	*
Miscellaneous Fees and Costs	*
TOTAL	*

* To be completed by amendment

Indemnification of Directors and Officers

The Delaware General Corporation Law, or DGCL, permits Delaware corporations to eliminate or limit the monetary liability of directors, officers, employees and agents for breach of fiduciary duty of care, subject to certain limitations. Our certificate of incorporation provides that our directors and officers shall not be liable to us or our stockholders for monetary damages arising from a breach of fiduciary duty owed by such director or officer, as applicable, except for liability (1) for any breach of a director's or officer's duty of loyalty to us or our stockholders, (2) for intentional misconduct, fraud or a knowing violation of law, under Section 174 of the DGCL or (3) for a transaction from which the officer or director derived an improper personal benefit. Our bylaws provide for the indemnification of our directors, officers, employees and agents to the extent permitted by the Delaware law. Our directors and officers are insured against certain liabilities for actions taken in such capacities, including liabilities under the Securities Act of 1933, as amended (the "Act").

Insofar as indemnification for liabilities arising under the Act may be permitted to directors, officers or persons controlling us pursuant to the foregoing, we have been informed that in the opinion of the Securities and Exchange Commission, or SEC, such indemnification is against public policy as expressed in the Act and is, therefore, unenforceable.

Recent Sales of Unregistered Securities

None.

Exhibits and Financial Statement Schedules

(a) *Exhibits*

No.	Description
1.0*	Form of Underwriting Agreement.
3.1	Articles of Incorporation (CA).
3.2	Certificate of Incorporation (DE).
3.3	Bylaws (CA).
3.4	Bylaws (DE).

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No.	Description
3.5*	Form of share certificate for common stock.
5.1*	Opinion of McDermott, Will & Emery.
10.1	Medi-Cal Agreement between Molina Medical Centers and the California Department of Health Services dated April 2, 1996, as amended.
10.2**	Health Services Agreement between Foundation Health, and Molina Medical Centers dated February 1, 1996, as amended.
10.3**	Contract Between Molina Healthcare of Michigan, Inc. and the State of Michigan effective October 1, 2000, as amended.
10.4**	HMO Contract between American Family Care and the Utah Department of Health effective July 1, 1999, as amended.
10.5**	Memorandum of Understanding between Molina Healthcare of Utah, Inc. and the Utah Department of Public Health effective July 1, 2002.
10.6	2003 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, 2003.
10.7	Employment Agreement with J. Mario Molina, M.D. dated January 2, 2002.
10.8	Employment Agreement with John C. Molina, J.D. dated January 1, 2002.
10.9	Employment Agreement with Mark L. Andrews, Esq. dated December 1, 2001.
10.10	Employment Agreement with George S. Goldstein, PhD. dated December 31, 2001.
10.11	Employment Agreement with M. Martha Bernadett, M.D. dated January 1, 2002.
10.12	2000 Omnibus Stock and Incentive Plan.
10.13	2002 Equity Incentive Plan.
10.14	2002 Employee Stock Purchase Plan.
21.1	List of subsidiaries.
23.1	Consent of Ernst & Young LLP, Independent Auditors.
23.2*	Consent of Deloitte & Touche LLP, Independent Auditors.

* To be filed by amendment.
** Confidential treatment has been requested for a portion of this Exhibit pursuant to Rule 406 promulgated under the Securities Act.

(b) *Financial Statement Schedules*

Molina Healthcare, Inc.

No.	Description
F-2	Report of Ernst & Young LLP, Independent Auditors
F-3	Report of Deloitte & Touche LLP, Independent Auditors
F-4	Consolidated Balance Sheets as of December 31, 2000 and 2001 and September 30, 2002 (unaudited)
F-5	Consolidated Statements of Income for the years ended December 31, 1999, 2000 and 2001 and the nine months ended September 30, 2001 and 2002 (unaudited)

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No.	Description
F-6	Consolidated Statements of Stockholders’ Equity for the years ended December 31, 1999, 2000 and 2001 and the nine months ended September 30, 2002 (unaudited)
F-7	Consolidated Statements of Cash Flows for the years ended December 31, 1999, 2000 and 2001 and the nine months ended September 30, 2001 and 2002 (unaudited)
F-9	Notes to Consolidated Financial Statements

QualMed Washington Health Plan, Inc.

No.	Description
F-30	Report of Ernst & Young LLP, Independent Auditors
F-31	Statement of Income and Comprehensive Income
F-32	Statement of Cash Flows
F-33	Notes to Financial Statements

Undertakings

The undersigned Registrant hereby undertakes:

(1) To file, during any period in which offers or sales are being made, a post-effective amendment to this registration statement:

(i) To include any prospectus required by Section 10(a)(3) of the Securities Act of 1933, as amended (the "Act");

(ii) To reflect in the prospectus any facts or events arising after the effective date of the registration statement (or the most recent post-effective amendment thereof) which, individually or in the aggregate, represent a fundamental change in the information set forth in the registration statement. Notwithstanding the foregoing, any increase or decrease in volume of securities offered (if the total dollar value of securities offered would not exceed that which was registered) and any deviation from the low or high end of the estimated maximum offering range may be reflected in the form of a prospectus filed with the SEC pursuant to Rule 424(b) if, in the aggregate, the changes in volume and price represent no more than a 20% change in the maximum aggregate offering price set forth in the "Calculation of Registration Fee" table in the effective registration statement;

(iii) To include any material information with respect to the plan of distribution not previously disclosed in the registration statement or any material change to such information in the registration statement.

(2) That, for the purpose of determining liability under the Act, each such post-effective amendment shall be deemed to be a new registration statement relating to the securities offered therein, and the offering of such securities at that time shall be deemed to be the initial bona fide offering thereof.

(3) To remove from registration by means of a post-effective amendment any of the securities being registered which remain unsold at the termination of the offering.

(4) That, for purposes of determining any liability under the Act, each filing of the registrant's annual report pursuant to section 13(a) or section 15(d) of the Securities Exchange Act of 1934 (and, where applicable, each filing of an employee benefit plan's annual report pursuant to section 15(d) of the Securities Exchange Act of 1934) that is incorporated by reference in the registration statement shall be deemed to be a new registration statement relating to the securities offered therein, and the offering of such securities at that time shall be deemed to be the initial bona fide offering thereof.

(5) To provide to the underwriter at the closing specified in the underwriting agreements certificates in such denominations and registered in such names as required by the underwriter to permit prompt delivery to each purchaser.

Insofar as indemnification for liabilities arising under the Act may be permitted to directors, officers and controlling persons of the Registrant pursuant to the foregoing provisions, or otherwise, the Registrant has been advised that in the opinion of the SEC such indemnification is against public policy as expressed in the Act and is, therefore, unenforceable. In the event that a claim for indemnification against such liabilities (other than the payment by the Registrant of expenses incurred or paid by a director, officer or controlling person of the Registrant in the successful defense of any action, suit or proceeding) is asserted by such director, officer or controlling person in connection with the securities being registered, the Registrant will, unless in the opinion of its counsel the matter has been settled by controlling precedent, submit to a court of appropriate jurisdiction the question of whether such indemnification by it is against public policy as expressed in the Securities Act and will be governed by the final adjudication of such issue.

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SIGNATURES

Pursuant to the requirements of the Act, the registrant has duly caused this registration statement to be signed on its behalf by the undersigned, thereunto duly authorized, in the City of Long Beach, State of California, on December 30, 2002.

MOLINA HEALTHCARE, INC.

By: /s/ J. MARIO MOLINA, M.D.

J. Mario Molina, M.D.
Chief Executive Officer
(Principal Executive Officer)

Pursuant to the requirements of the Act, this registration statement has been signed by the following persons in the capacities and on the dates indicated.

Signature	Title	Date
/s/ J. MARIO MOLINA, M.D. J. Mario Molina, M.D.	Chairman of the Board; Chief Executive Officer and President	December 30, 2002
/s/ JOHN C. MOLINA, J.D. John C. Molina, J.D.	Director; Executive Vice President, Financial Affairs, and Treasurer (Principal Financial Officer)	December 30, 2002
/s/ HARVEY A. FEIN Harvey A. Fein	Vice President, Financial Affairs (Principal Accounting Officer)	December 30, 2002
/s/ GEORGE S. GOLDSTEIN, PH.D. George S. Goldstein, Ph.D.	Director; Executive Vice President, Health Plan Operations	December 30, 2002
/s/ RONNA ROMNEY Ronna Romney	Director	December 30, 2002
/s/ RONALD LOSSETT, CPA, D.B.A. Ronald Lossett, CPA, D.B.A.	Director	December 30, 2002
/s/ CHARLES Z. FEDAK, CPA Charles Z. Fedak, CPA	Director	December 30, 2002

EXHIBIT 3.1

ARTICLES OF INCORPORATION
OF
AMERICAN FAMILY CARE, INC.

[SEAL]

I

The name of the Corporation is American Family Care, Inc.

II

The purpose of the Corporation is to engage in any lawful act or activity for which a corporation may be organized under the General Corporation Law of California other than the banking business, the trust company business or the practice of a profession permitted to be incorporated by the California Corporations Code.

III

The name and address in the State of California of the Corporation's initial agent for service of process are:

Mark L. Andrews
One Golden Shore Drive
Long Beach, CA 90802

IV

The Corporation is authorized to issue two classes of shares designated "Common Stock" and "Preferred Stock", respectively. The number of shares of Common Stock authorized to be issued is 5,000,000 and the number of shares of Preferred Stock authorized to be issued is 1,000,000.

The Board of Directors of the Corporation is authorized to (i) determine the number of series into which shares of Preferred Stock may be divided and the designation of any such series, (ii) determine the rights, preferences, privileges and restrictions granted to or imposed upon the Preferred Stock or any series thereof or any holders thereof, (iii) determine and alter the rights, preferences, privileges and restrictions granted to or imposed upon any wholly-unissued series of Preferred Stock or the holders thereof and (iv) fix the number of

shares constituting any series prior to the issue of shares of that series, and to increase or decrease, within the limits stated in any resolution or resolutions of the Board of Directors originally fixing the number of shares constituting any series (but not below the number of shares of such series then outstanding), the number of shares of any such series subsequent to the issue of shares of that series.

V

The liability of the directors of the Corporation for monetary damages shall be eliminated to the fullest extent permissible under California law. The Corporation is authorized to provide indemnification of agents (as defined in Section 317 of the California Corporations Code) for breach of duty to the Corporation and its shareholders through bylaw provisions or through agreements with the agents, or both, in excess of the indemnification otherwise permitted by Section 317 of the California Corporations Code, subject to the limits on such excess indemnification set forth in Section 204 of the California Corporations Code.

Dated: MAY 4, 1999

/s/

Incorporator

CERTIFICATE OF AMENDMENT

OF

ARTICLES OF INCORPORATION

OF

AMERICAN FAMILY CARE, INC.

[SEAL]

JOSEPH M. MOLINA and MARK L. ANDREWS, certify that:

1. They are the President and Secretary, respectively, of American Family Care, Inc, a California corporation.

2. Article I, of the Articles of Incorporation of this Corporation is amended and restated to read as follows:

I.

The name of the Corporation is Molina Healthcare, Inc.

3. The foregoing amendment of Articles of Incorporation has been duly approved by the Board of Directors.

4. The foregoing amendment and restatement of Articles of Incorporation has been duly approved by the required vote of shareholders in accordance with Section 902 of the Corporations Code. The total number of outstanding shares of the Corporation is 499,999.999. The number of shares voting in favor of the amendment equaled or exceeded the vote requirement. The percentage vote required was more than fifty percent (50%).

5. We further declare under penalty of perjury under the laws of the State of California that the matters set forth in this certificate are true, correct, and of our own knowledge.

Date:3/16/2000

/s/

Joseph M.Molina, President

Date:3/16/2000

/s/

Mark L.Andrews, Secretary

[SEAL]

EXHIBIT 3.2

[SEAL]

CERTIFICATE OF INCORPORATION

OF

MOLINA HEALTHCARE, INC.

ARTICLE I

The name of this Corporation shall be: Molina Healthcare, Inc.

ARTICLE II

The name of the registered office of the Corporation in the State of Delaware is The Corporation Trust Company, and the address of the registered agent at that address is 1209 Orange Street, City of Wilmington, County of New Castle, Delaware.

ARTICLE III

The purpose of the Corporation is to engage in any lawful act or activity for which corporations may be organized under the General Corporation Law of the State of Delaware (the "Delaware Corporation Law").

ARTICLE IV

A. The total number of shares of all classes of capital stock which the Corporation shall have the authority to issue is 100,000,000 shares, consisting of (a) 80,000,000 shares of Common Stock, par value $0.001 per share ("Common Stock"), and (b) 20,000,000 shares of Preferred Stock, par value $0.001 per share ("Preferred Stock").

B. Preferred Stock.

1. The Board of Directors of the Corporation (the "Board of Directors") is authorized to provide, by resolution, for one or more series of Preferred Stock to be comprised of authorized but unissued shares of Preferred Stock. Except as may be required by law, the shares in any series of Preferred Stock need not be identical to any other series of Preferred Stock. Before any shares of any such series of Preferred Stock are issued, the Board of Directors shall fix, and is hereby expressly empowered to fix, by resolution, rights, preferences and privileges of, and qualifications, restrictions and limitations applicable to such series, including the following:

(a) The designation of such series, the number of shares to constitute such series and the stated value thereof (if different from the par value thereof);

(b) Whether the shares of such series shall have voting rights (and, if so, the terms of such voting rights, which may be full, special or limited) and whether or not such series is to be entitled to vote as a separate class either alone or together with the holders of one or more other series or class of capital stock;

(c) The preferences and relative, participating, optional or other special rights, if any, and the qualifications, limitations or restrictions, if any, with respect to such series;

(d) The dividends, if any, payable on such series, whether any such dividends shall be cumulative (and, if so, from what dates), whether any such dividends are payable in cash, stock of the Corporation or other property or a combination thereof, the conditions and dates upon which such dividends shall be payable and the preference or relation which such dividends shall bear to the dividends payable on any shares of capita] stock of any other class or any other series of Preferred Stock;

(e) Whether the shares of such series shall be subject to redemption by the Corporation or upon the happening of any specified event, and, if so, the times, prices (which may be payable in the form of cash, notes, securities or other property or rights) and other conditions relating to such redemption;

(f) The amounts payable in respect of shares of such series, and the other rights and preferences of the holders of such shares, in the event of the voluntary or involuntary liquidation, dissolution or winding up, or upon any distribution of the assets, of the Corporation;

(g) Whether the shares of such series shall be subject to a retirement or sinking fund (and, if so, the extent to and manner in which any such retirement or sinking fund shall be applied to the purchase or redemption of the shares of such series for retirement or other corporate purposes and the other terms and provisions relating thereto);

(h) Whether the shares of such series shall be convertible into, or exchangeable for, shares of Common Stock or any other series of Preferred Stock, any other securities (whether or not issued by the Corporation) or any other property of the Corporation (and, if so, the price or prices or the rate or rates of such conversion or exchange, and any other terms and conditions of such conversion or exchange);

(i) The limitations and restrictions, if any, to be effective upon the payment of dividends or the making of other distributions on, or upon the purchase, redemption or other acquisition by the Company of, Common Stock or other shares of capital stock of any other class or any other series of Preferred Stock; and

(j) The conditions (if any) applicable to, or restrictions (if any) on, the creation of indebtedness of the Corporation or upon the issuance of any additional capital stock, including additional shares of such series or any other series of Preferred Stock or any other class of capital stock.

2. The Board of Directors is authorized to increase the number of shares of the Preferred Stock designated for any existing series of Preferred Stock by a resolution adding to such series authorized and unissued shares of the Preferred Stock not designated for any other series of Preferred Stock. The Board of Directors is authorized to decrease the number of shares of the Preferred Stock designated for any existing series of Preferred Stock by a resolution, subtracting from such series unissued shares of the Preferred Stock designated for such series.

C. Common Stock

1. Except as otherwise required by law, and subject to any special voting rights which may be granted to any series of Preferred Stock in the Board of Directors resolutions which create such series, each holder of Common Stock shall be entitled to one vote for each share of Common Stock standing in such holder's name on the records of the Corporation on each matter submitted to a vote of the stockholders. Holders of Common Stock shall not have the right to cumulative voting in the election of directors of the Corporation.

2. Subject to the rights of the holders of the Preferred Stock, the holders of the Common Stock shall be entitled to receive such dividends and other distributions, in cash, securities or property of the Corporation, as may be declared thereon from time to time by the Board of Directors, out of the assets and funds of the Corporation legally available therefor.

3. Upon any liquidation, dissolution or winding up of the Corporation, the holders of the Common Stock shall be entitled to receive, ratably in accordance with the shares of Common Stock held by them, any amounts remaining after payment of the holders of the Preferred Stock.

D. General.

1. Subject to the foregoing provisions of this Certificate of Incorporation, the Corporation may issue shares of its Preferred Stock and Common Stock from time to time for such consideration (in any form, but not less in value than the par value thereof) as may be fixed by the Board of Directors, which is expressly authorized to fix such consideration in its absolute and uncontrolled discretion subject to the foregoing conditions. Shares of Preferred Stock or Common Stock so issued for which the consideration shall have been paid or delivered to the Corporation shall be deemed fully paid stock and shall not be subject to any further call or assessment thereon, and the holders of such shares shall not be liable for any further payments in respect of such shares.

2. The Corporation shall have authority to create and grant rights and options entitling their holders to purchase or otherwise acquire shares of any class or series of the Corporation's capital stock or other securities of the Corporation, and such rights and options shall be evidenced by instruments approved by the Board of Directors. The Board of Directors shall be empowered to set the exercise price, duration, times for exercise and other terms of such options or rights; provided, however, that the consideration to be

received (which may be in any form permitted by the Board of Directors) for any shares of capital stock subject thereto shall have a value not less than the par value thereof.

ARTICLE V

A. The management of the business and the conduct of the affairs of the Corporation shall be vested in the Board of Directors of the Corporation. The number of directors which shall constitute the entire Board of Directors shall be fixed by, or in the manner provided in, the Bylaws of the Corporation, subject to any restrictions that may be set forth in this Certificate.

B. The directors of the Corporation shall be classified, with respect to the time for which they hold office, into three classes as nearly equal in number as possible: one class the term of which expires at the first annual meeting of stockholders that is held after the first organizational meeting of the Board of Directors, a second class the term of which expires at the second annual meeting of stockholders that it held after the first organizational meeting of the Board of Directors and a third class the term of which expires at the third annual meeting of stockholders that is held after the first organizational meeting of the Board of Directors, with the directors in each such class to hold office until their successors are elected and qualified. If the number of directors is changed by the Board of Directors, then any newly-created directorships or any decrease in directorships shall be so apportioned among such classes as to make all such classes as nearly equal in number as possible; provided, however, that no decrease in the number of directors shall shorten the term of any incumbent director. At each annual meeting of the stockholders of the Corporation, subject to the rights of the holders of any class or series of capital stock having a preference over Common Stock as to dividends or upon liquidation, the successors of the class of directors the term of which expires at such meeting shall be elected to hold office for a term expiring at the annual meeting of stockholders of the Corporation held in the third year following the year of such election.

ARTICLE V1

In furtherance and not in limitation of the powers conferred by statute, the Board of Directors is expressly authorized to make, repeal, alter, amend and rescind the Bylaws of the Corporation; provided, however, that the stockholders may change or repeal any Bylaw adopted by the Board of Directors by the affirmative vote of the percentage of holders of capital stock as set forth therein.

ARTICLE VII

The election of directors at an annual or special meeting of stockholders of the Corporation need not be by written ballot unless the Bylaws of the Corporation shall so provide.

ARTICLE VIII

A. The Corporation shall indemnify any person who was or is a party or is threatened to be made a party to any threatened, pending or completed action, suit or proceeding, whether civil, criminal, administrative or investigative, by reason of the fact that such person is or was a director or an officer of the Corporation against expenses (including, without limitation, attorneys' fees), judgments, fines and amounts paid in settlement actually and reasonably incurred thereby in connection with such action, suit or proceeding to the fullest extent permitted by the Delaware Corporation Law and any other applicable law as shall be from time to time in effect. Such right of indemnification shall not be deemed to be exclusive of any rights to which any such director or officer may otherwise be entitled. The provisions of this Article VIII--Section A shall be deemed to constitute a contract between the Corporation and each director and officer of the Corporation serving in such capacity at any time while this Article VIII--Section A is in effect, and any repeal or modification thereof shall not affect any right or obligation then existing with respect to any state of facts then or theretofore existing or any action, suit or proceeding theretofore or thereafter brought or threatened based in whole or in part upon any such state of facts.

B. The Corporation shall indemnify any person who was or is a party or is threatened to be made a party to any threatened, pending or completed action, suit or proceeding, whether civil, criminal, administrative or investigative, by reason of the fact that such person is or was serving at the request of the Corporation as a director, officer, employee or agent of another corporation, partnership, joint venture, trust or other enterprise including service with respect to an employee benefit plan, against expenses (including, without limitation, attorneys' fees), judgments, fines and amounts paid in settlement actually and reasonably incurred thereby in connection with such action, suit or proceeding to the extent permitted by and in the manner set forth in the Delaware Corporation Law and any other applicable law as shall be from time to time in effect. Such right of indemnification shall not be deemed to be exclusive of any other rights to which any such person may otherwise be entitled.

ARTICLE IX

To the fullest extent permitted by the Delaware Corporation Law, a director of the Corporation shall not be liable to the Corporation or its stockholders for monetary damages for breach of fiduciary duty as a director. In furtherance thereof, a director of the Corporation shall not be personally liable to the Corporation or its stockholders for monetary damages for breach of fiduciary duty as a director, except for liability (i) for any breach of the director's duty of loyalty to the Corporation or its stockholders, (ii) for acts or omissions not in good faith or which involve intentional misconduct or a knowing violation of law, (iii) under Section 174 of the Delaware Corporation Law, as currently in existence or hereafter amended, or (iv) for any transaction from which the director derived an improper personal benefit. If the Delaware Corporation Law hereafter is amended to authorize the further elimination or limitation of the liability of directors, then the liability of directors shall be eliminated or limited to the full extent authorized by the Delaware Corporation Law, as so amended.

ARTICLE X

A. Special meetings of the stockholders of the Corporation for any purpose or purposes may be called at any time by the President or Chief Executive Officer of the Corporation, the Chairperson of the Board of Directors or the Board of Directors or a Committee of the Board of Directors which has been duly designated by the Board of Directors and the powers and authority of which, as provided in a resolution of the Board of Directors or in the Bylaws of the Corporation, include the power to call special meetings of the stockholders. Such special meetings may not be called by any other person or persons.

B. So long as the Corporation has more than one stockholder, no action required to be taken or which may be taken at any annual or special meeting of the stockholders of the Corporation may be taken without such a meeting, and the power of the stockholders to consent in writing, without a meeting, to the taking of any action is specifically denied.

ARTICLE XI

Notwithstanding any other provision of this Certificate of Incorporation or any provision of law which might otherwise permit a lesser vote or no vote, but in addition to any affirmative vote of the holders of any particular class or series of the capital stock of the Corporation required by law, this Certificate of Incorporation or any designation of the Preferred Stock, the affirmative vote of at least fifty percent (50%) of the voting power of all of the then outstanding shares of the capital stock, voting together as a single class, shall be required to amend, alter or appeal any provision contained in this Certificate of Incorporation.

ARTICLE XII

The name and mailing address of the incorporator of the Corporation is:

Elliot Hinds
McDermott. Will & Emery
2049 Century Park East, 34th Floor
Los Angeles, California 90067

THE UNDERSIGNED, being the sole incorporator herein named, for the purpose of forming a corporation pursuant to the Delaware Corporation Law, does make this certificate, hereby declaring and certifying that the facts stated herein are true, and accordingly have hereunto set my hand as of July 24, 2002.

/s/

Elliot Hinds, Sole Incorporator

EXHIBIT 3.3

BYLAWS

OF

MOLINA HEALTHCARE, INC., a California corporation

ARTICLE I

Applicability

Section 1. Applicability of Bylaws.

Except as otherwise provided by statute or its Articles of Incorporation, these Bylaws govern the management of the business and the conduct of the affairs of the Corporation.

ARTICLE II

Offices

Section 1. Principal Executive Office.

The Board of Directors shall fix the location of the principal executive office of the Corporation within or outside the State of California. If the principal executive office is located outside the State of California, and the Corporation has one or more business offices within California, the Board of Directors shall fix and designate a principal business office within the State of California.

Section 2. Other Offices.

The Board of Directors may establish other offices at any place or places within or without the State of California.

Section 3. Change in Location or Number of Offices.

The Board of Directors may change any office from one location to another or eliminate any office or offices.

ARTICLE III

Meetings of Shareholders

Section 1. Place of Meetings.

Meetings of the shareholders shall be held at any place within or without the State of California designated by the Board of Directors or, in the absence of such designation, at the principal executive office of the Corporation.

Section 2. Annual Meetings.

An annual meeting of the shareholders shall be held following the end of the fiscal year of the Corporation at a date and time designated by the Board of Directors. Directors shall be elected at each annual meeting and any other proper business may be transacted at such annual meeting.

Section 3. Special Meetings.

(a) Special meetings of the shareholders may be called by adoption of an appropriate resolution of a majority of the Board of Directors or upon the request of the Chairman of the Board, the President or the holders of shares entitled to cast not less than 10% of the votes at such meeting.

(b) Any officer or shareholder request for the calling of a special meeting of the shareholders shall (1) be in writing, (2) specify the date, which shall be not less than 35 or more than 60 days after the receipt of the request, and the time thereof, (3) specify the general nature of the business to be transacted at such special meeting and (4) be given either personally or by first-class mail, postage prepaid, or other means of written communication to the Chairman of the Board, President, any vice president or Secretary of the Corporation. The officer receiving a proper request to call a special meeting of the shareholders shall, within 20 days after receipt of such request, cause notice to be given pursuant to the provisions of Section 4 of this Article to the shareholders entitled to vote at such special meeting that a meeting will be held at the date and time specified by the person or persons calling the meeting.

(c) No business may be transacted at a special meeting unless the general nature thereof was stated in the notice of such meeting.

Section 4. Notice of Annual, Special or Adjourned Meetings.

(a) Whenever any meeting of the shareholders is to be held, a written notice of such meeting shall be given in the manner described in subdivision (d) of this Section not less than 10 (or, if sent by third-class mail, 30) nor more than 60 days before the date thereof to each shareholder entitled to vote at such meeting. The notice shall state the place, date and hour of the meeting and (1) in the case of a special meeting, the general nature of the business to be transacted or (2) in the case of the annual meeting, those matters which the Board of Directors, at the time of the giving of the notice, intend to present for action by the shareholders including, whenever directors are to be elected at a meeting, the names of nominees intended at the time of giving of the notice to be presented by the Board of Directors for election.

(b) Any proper matter may be presented at an annual meeting for action, except as is provided in subdivision (f) of Section 601 of the Corporations Code of the State of California.

(c) Notice need not be given of an adjourned meeting if the time and place thereof are announced at the meeting at which the adjournment is taken; provided that, if the adjournment is for more than 45 days or if after the adjournment a new record date is provided for the adjourned meeting, a notice of the adjourned meeting shall be given to each shareholder of record entitled to vote at such adjourned meeting.

(d) Notice of any meeting of the shareholders or any report shall be given either personally or by first-class mail or by other means of written communication, addressed to the shareholder at such shareholder's address appearing on the books of the Corporation or given by such shareholder to the Corporation for the purpose of notice. If no such address appears or is given, notice shall be deemed to be given if sent to that shareholder by first-class mail to the Corporation's principal executive office or if published at least once in a newspaper of general circulation in the county in which the principal executive office is located. The notice or report shall be deemed to have been given at the time when delivered personally to the recipient or deposited in the mail or sent by other means of written communication. An affidavit of mailing of any notice or report in accordance with the provisions of these Bylaws or the General Corporation Law of the State of California, executed by the Secretary, assistant secretary or any transfer agent of the Corporation, shall be prima facie evidence of the giving of the notice or report.

(e) If any notice or report addressed to the shareholder at such shareholder's address appearing on the books of the Corporation is returned to the Corporation by the United States Postal Service marked to indicate that the United States Postal Service is unable to deliver the notice to the shareholder at such address, all future notices or reports shall be deemed to have been duly given without further mailing if the same shall be available for the shareholder upon such shareholder's written demand at the Corporation's principal executive office for a period of one year from the date of the giving of the notice to all other shareholders.

Section 5. Record Date.

(a) The Board of Directors may fix a time in the future as a record date for the determination of the shareholders (1) entitled to notice of any meeting or to vote at such meeting, (2) entitled to receive payment of any dividend or other distribution or allotment of any rights or (3) entitled to exercise any rights in respect of any other lawful action. The record date so fixed shall be not more than 60 nor less than 10 days prior to the date of any meeting of the shareholders nor more than 60 days prior to any other action.

(b) In the event no record date is fixed:

(1) The record date for determining the shareholders entitled to notice of or to vote at a meeting of shareholders shall be at the close of business on the business day next preceding the day on which notice is given or, if the notice is waived, at the close of business on the business day next preceding the day on which the meeting is held;

(2) The record date for determining shareholders entitled to give consent to corporate action in writing without a meeting, when no prior action by the Board of Directors has been taken, shall be the day on which the first written consent is given;

(3) The record date for determining shareholders for any other purpose shall be at the close of business on the day on which the Board of Directors adopts the resolution relating thereto, or the 60th day prior to the date of such other action, whichever is later.

(c) Only shareholders of record on the close of business on the record date are entitled to notice of and to vote at the relevant meeting of shareholders, or to receive a dividend, distribution or allotment of rights or to exercise the rights, as the case may be, notwithstanding any transfer of any shares on the books of the Corporation after the record date.

(d) A determination of shareholders of record entitled to notice of or to vote at a meeting of shareholders shall apply to any adjournment of the meeting unless the Board of Directors fixes a new record date for the adjourned meeting, but the Board shall fix a new record date if the meeting is adjourned for more than 45 days from the date set for the original meeting.

Section 6. Quorum.

(a) A majority of the shares entitled to vote at a meeting of the shareholders, represented in person or by proxy, shall constitute a quorum for the transaction of business at such meeting.

(b) Except as provided in Section 6(c) below, the affirmative vote of a majority of the shares represented and voting at a duly held meeting at which a quorum is present (which shares voting affirmatively also constitute at least a majority of the required quorum) shall be the act of the shareholders, unless the vote of a greater number is required by law or the Articles of Incorporation.

(c) The shareholders present at a duly called or held meeting at which a quorum is present may continue to transact business until adjournment notwithstanding the withdrawal of enough shareholders to leave less than a quorum, provided that any action taken (other than adjournment) is approved by at least a majority of the shares required to constitute a quorum.

Section 7. Adjournment.

Any meeting of the shareholders may be adjourned from time to time whether or not a quorum is present by the vote of a majority of the shares represented at such meeting either in person or by proxy. At the adjourned meeting the Corporation may transact any business which might have been transacted at the original meeting.

Section 8. Validation of Defectively Called, Noticed or Held Meetings.

(a) The actions taken at any meeting of the shareholders, however called and noticed, and wherever held, are as valid as though taken at a meeting duly held after regular call and notice, if a quorum is present either in person or by proxy, and if, either before or after the meeting, each of the persons entitled to vote at such meeting and not present in person or by proxy, signs a written waiver of notice or a consent to the holding of the meeting or an approval of the minutes thereof. All such waivers, consents and approvals shall be filed with the corporate records or made a part of the minutes of the meeting.

(b) Attendance of a person at a meeting shall constitute a waiver of notice of that meeting, except (1) when the person objects, at the beginning of the meeting, to the transaction of any business because the meeting is not lawfully called or convened, and (2) that attendance at a meeting is not a waiver of any right to object to the consideration of any matter required by the General Corporation Law of the State of California to be included in the notice but not so included, if that objection is expressly made at the meeting.

(c) Any written waiver of notice shall comply with subdivision (f) of Section 601 of the Corporations Code of the State of California.

Section 9. Voting for Election of Directors.

(a) Every shareholder complying with subdivision (b) of this section and entitled to vote at any election of directors may cumulate such shareholder's votes and give one candidate a number of votes equal to the number of directors to be elected multiplied by the number of votes to which such shareholder's shares are normally entitled, or distribute such shareholder's votes on the same principle among as many candidates as such shareholder thinks fit.

(b) No shareholder shall be entitled to cumulate such shareholder's votes (i.e., cast for any candidate a number of votes greater than the number of votes which such shareholder's shares are normally entitled to cast) unless the candidate's or candidates' names for which such shareholder desires to cumulate such shareholder's votes have been placed in nomination prior to the voting and the shareholder has given notice at the meeting prior to the voting of such shareholder's intention to cumulate such shareholder's votes. If any one shareholder has given such notice, all shareholders may cumulate their votes for candidates in nomination.

(c) Election for directors may be by voice vote or by ballot unless any shareholder entitled to vote demands election by ballot at the meeting prior to the voting, in which case the vote shall be by ballot.

(d) In any election of directors, the candidates receiving the highest number of affirmative votes of the shares entitled to be voted, up to the number of directors to be elected by such shares, shall be elected as directors; votes against any director and votes withheld shall have no legal effect.

Section 10. Proxies.

(a) Every person entitled to vote shares may authorize another person or persons to act with respect to such shares by a written proxy signed by such shareholder or such shareholder's attorney-in-fact and filed with the Secretary of the Corporation. A proxy shall be deemed signed if the shareholder's name is placed on the proxy (whether by manual signature, typewriting, telegraphic transmission or otherwise) by such shareholder or such shareholder's attorney-in-fact.

(b) Any duly executed proxy shall continue in full force and effect until the expiration of the term specified therein or upon its earlier revocation by the person executing it prior to the vote pursuant thereto (1) by a writing delivered to the Corporation stating that it is revoked, (2) by a subsequent proxy executed by the person executing the prior proxy and presented to the meeting, or (3) as to any meeting by attendance at the meeting and voting in person by the

person executing the proxy. No proxy shall be valid after the expiration of 11 months from the date thereof unless otherwise provided in the proxy. The date contained on the form of proxy shall be deemed to be the date of its execution.

(c) A proxy which states that it is irrevocable is irrevocable for the period specified therein subject to the provisions of subdivisions (e) and (f) of Section 705 of the Corporations Code of the State of California.

Section 11. Inspectors of Election.

(a) In advance of any meeting of the shareholders, the Board of Directors may appoint either any one or three persons (other than nominees for the office of director) as inspectors of election to act at such meeting or any adjournments thereof. If inspectors of election are not so appointed, or if any person so appointed fails to appear or refuses to act, the Chairman of any such meeting may, and on the request of any shareholder or such shareholder's proxy shall, appoint inspectors of elections (or persons to replace those who so fail or refuse to act) at the meeting. If appointed at a meeting on the request of one or more shareholders or the proxies thereof, the majority of shares represented in person or by proxy shall determine whether one or three inspectors are to be appointed.

(b) The duties of inspectors of election and the manner of performance thereof shall be as prescribed in Section 707 of the Corporations Code of the State of California.

Section 12. Action by Written Consent.

(a) Subject to subdivisions (b) and (c) of this section, any action which may be taken at any annual or special meeting of the shareholders may be taken without a meeting, without a vote and without prior notice, if a consent in writing, setting forth the action so taken, is signed by the holders of outstanding shares having not less than the minimum number of votes which would have been necessary to authorize or take such action at a meeting in which all shares entitled to vote thereon were present and voted. All such consents shall be filed with the Secretary of the Corporation and maintained with the corporate records.

(b) Except for the election of a director by written consent to fill a vacancy (other than a vacancy created by removal), directors may be elected by written consent only by the unanimous written consent of all shares entitled to vote for the election of directors. In the case of an election of a director by written consent to fill a vacancy (other than a vacancy created by removal), any such election requires the consent of a majority of the outstanding shares entitled to vote.

(c) Unless the consents of all shareholders entitled to vote have been solicited in writing, notice of any shareholder approval without a meeting by less than unanimous written consent shall be given as provided in subdivision (b) of Section 603 of the Corporations Code of the State of California.

(d) Any shareholder giving a written consent, or such shareholder's proxy holders, or a personal representative of the shareholder or their respective proxy holders, may revoke the consent by a writing received by the Corporation prior to the time that written consents of the number of shares required to authorize the proposed action have been filed with the Secretary of the Corporation, but may not do so thereafter. Such revocation is effective upon its receipt by the Secretary of the Corporation.

ARTICLE IV

Directors

Section 1. Number and Qualification of Directors.

(a) The authorized number of directors shall be not less than five (5) nor more than nine (9). The exact number of directors shall be fixed from time to time, within the limits specified in this subdivision, by an amendment of subdivision (b) of this Section adopted by the Board of Directors.

(b) The exact number of directors shall be seven (7) until changed as provided in subdivision (a) of this Section.

(c) The maximum or minimum authorized number of directors may only be changed by an amendment of this Section approved by the vote or written consent of a majority of the outstanding shares entitled to vote; provided, however, that in no case shall the stated maximum number of authorized directors exceed two times the stated minimum number of authorized directors minus one; provided, further, that an amendment reducing the minimum number of directors to a number less than five shall not be adopted if the votes cast against its adoption at a meeting (or the shares not consenting in the case of action by written consent) exceed 16-2/3% of the outstanding shares entitled to vote.

Section 2. Election of Directors.

Directors shall be elected at each annual meeting of the shareholders.

Section 3. Term of Office.

Each director, including a director elected to fill a vacancy, shall hold office until the expiration of the term for which he is elected and until a successor has been elected.

Section 4. Vacancies.

(a) A vacancy in the Board of Directors exists whenever any authorized position of director is not then filled by a duly elected director, whether caused by death, resignation, removal, change in the authorized number of directors or otherwise.

(b) Except for a vacancy created by the removal of a director, vacancies on the Board of Directors may be filled by a majority of the directors then in office, whether or not less than a quorum, or by a sole remaining director. A vacancy created by the removal of a director shall be filled only by shareholders.

(c) The shareholders may elect a director at any time to fill any vacancy not filled by the directors. Any such election by written consent other than to fill a vacancy created by removal requires the consent of a majority of the outstanding shares entitled to vote.

Section 5. Removal.

(a) The Board of Directors may declare vacant the office of a director who has been declared of unsound mind by an order of court or convicted of a felony.

(b) Any or all of the directors may be removed without cause if such removal is approved by a majority of the outstanding shares entitled to vote; provided, however, that no director may be removed (unless the entire Board of Directors is removed) if the votes cast against removal, or not consenting in writing to such removal, would be sufficient to elect such director if voted cumulatively at an election at which the same total number of votes were cast (or, if such action is taken by written consent, all shares entitled to vote were voted) and the entire number of directors authorized at the time of such shareholder's most recent election were then being elected.

(c) Any reduction of the authorized number of directors does not remove any director prior to the expiration of such director's term of office.

Section 6. Resignation.

Any director may resign effective upon giving written notice to the Chairman of the Board, the President, the Secretary or the Board of Directors of the Corporation, unless the notice specifies a later time for the effectiveness of such resignation. If the resignation is effective at a future time, a successor may be elected to take office when the resignation becomes effective.

Section 7. Fees and Compensation.

Directors may be reimbursed for their expenses, if any, for attendance at each meeting of the Board of Directors and may be paid a fixed sum determined by resolution of the Board of Directors for attendance at each such meeting. No such payments shall preclude any director from serving the Corporation in any other capacity and receiving compensation in any manner therefor.

Section 8. Approval of Loans to Officers

The Corporation may, upon the approval of the Board of Directors alone, make loans of money or property to, or guarantee the obligations of, any officer of the Corporation or its parent or subsidiary, whether or not a director, or adopt an employee benefit plan or plans authorizing such loans or guaranties provided that (i) the Board of Directors determines that such a loan or guaranty or plan may reasonably be expected to benefit the corporation, and (ii) the approval of the Board of Directors is by a sufficient vote without counting the vote of any interested director or directors.

ARTICLE V

Committees of the Board of Directors

Section 1. Designation of Committees.

The Board of Directors may, by resolution adopted by a majority of the authorized number of directors, designate (1) one or more committees, each consisting of two or more directors and (2) one or more directors as alternate members of any committee, who may replace any absent member at any meeting of the committee. The appointment of members or alternative members of a committee requires the vote of a majority of the authorized number of directors. Any member or alternate member of a committee shall serve at the pleasure of the Board.

Section 2. Powers of Committees.

Any committee, to the extent provided in the resolution of the Board of Directors designating such committee, shall have all the authority of the Board, except with respect to:

(a) The approval of any action for which the General Corporation Law of the State of California also requires approval by the shareholders;

(b) The filling of vacancies on the Board or in any committee thereof;

(c) The fixing of compensation of the directors for serving on the Board or on any committee thereof;

(d) The amendment or repeal of these bylaws or the adoption of new bylaws;

(e) The amendment or repeal of any resolution of the Board which by its express terms is not so amendable or repealable;

(f) A distribution to the shareholders of the Corporation, except at a rate or in a periodic amount or within a price range determined by the Board of Directors; or

(g) The designation of other committees of the Board or the appointment of members or alternate members thereof.

ARTICLE VI

Meetings of the Board of Directors
and Committees Thereof

Section 1. Place of Meetings.

Regular meetings of the Board of Directors shall be held at any place within or without the State of California which has been designated from time to time by the Board or, in the absence of such designation, at the principal executive office of the Corporation. Special meetings of the Board shall be held either at any place within or without the State of California which has

been designated in the notice of the meeting or, if not stated in the notice or there is no notice, at the principal executive office of the Corporation.

Section 2. Organization Meeting.

Immediately following each annual meeting of the shareholders, the Board of Directors shall hold a regular meeting for the purpose of organization and the transaction of other business. Notice of any such meeting is not required.

Section 3. Other Regular Meetings.

Other regular meetings of the Board of Directors shall be held without call at such time as shall be designated from time to time by the Board. Notice of any such meeting is not required.

Section 4. Special Meetings.

Special meetings of the Board of Directors may be called at any time for any purpose or purposes by the Chairman of the Board or the President or any vice president or the Secretary or any two directors. Notice shall be given of any special meeting of the Board.

Section 5. Notice of Special Meetings.

(a) Notice of the time and place of special meetings of the Board of Directors shall be delivered personally or by telephone to each director or sent to each director by first-class mail or telegraph, charges prepaid. Such notice shall be given four days prior to the holding of the special meeting if sent by mail or 48 hours prior to the holding thereof if delivered personally or given by telephone or telegraph. The notice shall be deemed to have been given at the time when delivered personally to the recipient or deposited in the mail or sent by other means of written communication.

(b) Notice of any special meeting of the Board of Directors need not specify the purpose thereof and need not be given to any director who signs a waiver of notice or a consent to holding the meeting or an approval of minutes thereof, whether before or after the meeting, or who attends the meeting without protesting, prior thereto or at its commencement, the lack of notice to such director. All such waivers, consents and approvals shall be filed with the corporate records or made a part of the minutes.

Section 6. Quorum; Action at Meetings; Telephone Meetings.

(a) A majority of the authorized number of directors shall constitute a quorum for the transaction of business. Every act or decision done or made by a majority of the directors present at a meeting held duly at which a quorum is present is the act of the Board of Directors, unless action by a greater proportion of the directors is required by law or the Articles of Incorporation.

(b) A meeting at which a quorum is initially present may continue to transact business notwithstanding the withdrawal of directors, if any action taken is approved by at least a majority of the required quorum for such meeting.

(c) Members of the Board of Directors may participate in a meeting through use of conference telephone or similar communications equipment, so long as all members participating in such meeting can hear one another. A member who participates in a meeting pursuant to this subdivision (c) shall be deemed 'present' at such meeting for purposes of these Bylaws.

Section 7. Adjournment.

A majority of the directors present, whether or not a quorum is present, may adjourn any meeting to another time and place. If the meeting is adjourned for more than 24 hours, notice of any adjournment to another time or place shall be given prior to the time of the adjourned meeting to the directors who were not present at the time of the adjournment.

Section 8. Action Without a Meeting.

Any action required or permitted to be taken by the Board of Directors may be taken without a meeting, if all members of the Board individually or collectively consent in writing to such action. Such written consent or consents shall be filed with the minutes of the proceedings of the Board. Such action by written consent shall have the same force and effect as a unanimous vote of such directors.

Section 9. Meetings of and Action by Committees.

The provisions of this Article apply to committees of the Board of Directors and incorporators and action by such committees and incorporators with such changes in the language as are necessary to reflect the applicability of such provisions to such committees and incorporators.

ARTICLE VII

Officers

Section 1. Officers.

The Corporation shall have as officers, a President, a Secretary and a Treasurer. The Treasurer is the Chief Financial Officer of the Corporation unless the Board of Directors has by resolution designated another person to be the Chief Financial Officer. The Corporation may also have at the discretion of the Board, a Chairman of the Board, one or more Vice Presidents, one or more Assistant Secretaries, one or more Assistant Treasurers and such other officers as may be appointed in accordance with the provisions of Section 3 of this Article. One person may hold two or more offices.

Section 2. Election of Officers.

The officers of the Corporation, except such officers as may be appointed in accordance with the provisions of Section 3 or Section 5 of this Article, shall be chosen by the Board of Directors.

Section 3. Subordinate Officers, Etc.

The Board of Directors may appoint by resolution, and may empower the Chairman of the Board, if there be such an officer, or the President, to appoint such other officers as the business of the Corporation may require, each of whom shall hold office for such period, have such authority and perform such duties as are determined from time to time by resolution of the Board or, in the absence of any such determination, as are provided in these Bylaws. Any appointment of an officer shall be evidenced by a written instrument filed with the Secretary of the Corporation and maintained with the corporate records.

Section 4. Removal and Resignation.

(a) Subject to the provisions of any employment or other agreement, any officer may be removed, either with or without cause, by the Board of Directors or, except in case of any officer chosen by the Board, by any officer upon whom such power of removal be conferred by resolution of the Board.

(b) Any officer may resign at any time effective upon giving written notice to the Chairman of the Board, President, any Vice President or Secretary of the Corporation, unless the notice specifies a later time for the effectiveness of such resignation.

Section 5. Vacancies.

A vacancy in any office because of death, resignation, removal, disqualification or any other cause shall be filled in the manner prescribed in these Bylaws for regular appointments to such office.

Section 6. Chairman of the Board.

If there is a Chairman of the Board, he or she shall preside at all meetings of the Board of Directors and shareholders and exercise and perform such other powers and duties as may be from time to time assigned to the Chairman by resolution of the Board.

Section 7. President.

Subject to such supervisory powers, if any, as may be given by the Board of Directors to the Chairman of the Board, if there be such an officer, the President shall be the chief executive officer and general manager of the Corporation and shall, subject to the control of the Board, have general supervision, direction and control of the business and affairs of the Corporation. In the absence of the Chairman of the Board, or if there be none, the President shall preside at all meetings of the shareholders and at all meetings of the Board. He or she shall have the general powers and duties of management usually vested in the office of president of a corporation, and shall have such other powers and duties as may be prescribed from time to time by resolution of the Board.

Section 8. Vice President.

In the absence or disability of the President, the Vice Presidents in order of their rank as fixed by the Board of Directors or, if not ranked, the Vice President designated by the Board, shall perform all the duties of the President, and when so acting shall have all the powers of, and be subject to all the restrictions upon, the President. The vice presidents shall have such other powers and perform such other duties as from time to time may be prescribed for them respectively by the Board or as the President may from time to time delegate.

Section 9. Secretary.

(a) The Secretary shall keep or cause to be kept the minute book, the share register and the seal, if any, of the Corporation.

(b) The Secretary shall give, or cause to be given, notice of all meetings of the shareholders and of the Board of Directors required by these Bylaws or by law to be given, and shall have such other powers and perform such other duties as may be prescribed from time to time by the Board.

Section 10. Treasurer.

(a) The Treasurer of the Corporation shall keep, or cause to be kept, the books and records of account of the Corporation.

(b) The Treasurer shall deposit all monies and other valuables in the name and to the credit of the Corporation with such depositories as may be designated from time to time by resolution of the Board of Directors. He or she shall disburse the funds of the Corporation as may be ordered by the Board of Directors, shall render to the President and the Board, whenever they request it, an account of all of such officer's transactions as Treasurer and of the financial condition of the Corporation, and shall have such other powers and perform such other duties as may be prescribed from time to time by the Board or as the President may from time to time delegate.

ARTICLE VIII

Records and Reports

Section 1. Minute Book Maintenance and Inspection.

The Corporation shall keep or cause to be kept in written form at its principal executive office, or such other place as the Board of Directors may order, a minute book which shall contain a record of all actions by its shareholders, Board or committees of the Board including the time, date and place of each meeting; whether a meeting is regular or special and, if special, how called; the manner of giving notice of each meeting and a copy thereof; the names of those present at each meeting of the Board or committees thereof; the number of shares present or represented at each meeting of the shareholders; the proceedings of all meetings; any written waivers of notice, consents to the holding of a meeting or approvals of the minutes thereof; and, written consents for action without a meeting.

Section 2. Share Register - Maintenance and Inspection.

The Corporation shall keep or cause to be kept at its principal executive office, or if so provided by resolution of the Board of Directors, with the Corporation's transfer agent or

registrar, a share register, or a duplicate share register, which shall contain the names of the shareholders and their addresses, the number and classes of shares held by each, the number and date of certificates issued for the same and the number and date of cancellation of every certificate surrendered for cancellation.

Section 3. Books and Records of Account - Maintenance and Inspection.

The Corporation shall keep or cause to be kept at its principal executive office, or such other place as the Board of Directors may order, adequate and correct books and records of account.

Section 4. Bylaws - Maintenance and Inspection.

The Corporation shall keep at its principal executive office, or in the absence of such office in the State of California, at its principal business office in that state, the original or a copy of the Bylaws as amended to date.

Section 5. Annual Report to Shareholders.

The Board of Directors shall cause the Corporation to send an annual report to the shareholders not later than 120 days after the close of the fiscal year of the Corporation; provided, however, that the Corporation shall not be obligated to send such annual report so long as it has fewer than 100 holders of record of its shares. Any such report shall comply with the provisions of Section 1501 of the California Corporations Code and shall be sent in a manner specified in Section 4(d) of Article III of these Bylaws at least 15 days prior to the annual meeting of shareholders to be held during the next fiscal year.

ARTICLE IX

Indemnification of Directors, Officers and Employees

The Corporation shall, to the maximum extent permitted by the General Corporation Law of the State of California, and as the same from time to time may be amended, indemnify each of its agents against expenses, judgments, fines, settlements and other amounts actually and reasonably incurred in connection with any proceeding to which such person was or is a party or is threatened to be made a party arising by reason of the fact that such person is or was an agent of the Corporation. For purposes of this Article IX, an "agent" of the Corporation

includes any person who is or was serving at the request of the Corporation as a director, officer, employee or agent of another foreign or domestic corporation, partnership, joint venture, trust or other enterprise, or was a director, officer, employee or agent of a foreign or domestic corporation which was a predecessor corporation of the Corporation or of another enterprise at the request of such predecessor corporation; "proceeding" means any threatened, pending or completed action or proceeding, whether civil, criminal, administrative or investigative, and includes an action or proceeding by or in the right of the Corporation to procure a judgment in its favor; and "expenses" includes attorneys' fees and any expenses of establishing a right to indemnification under this paragraph.

The right of indemnification provided in this Article IX shall inure to each person referred to herein, and shall extend to such person's legal representatives in the event of such person's death. The right of indemnification provided herein shall not be exclusive of any other rights to which any such person, or any other individual, may be entitled as a matter of law, or pursuant to any agreement, vote of directors or shareholders or otherwise.

The Corporation shall, if and to the extent the Board of Directors so determines by resolution, purchase and maintain insurance in an amount and on behalf of such agents of the Corporation as the Board may specify in such resolution against any liability asserted against or incurred by the agent in such capacity or arising out of the agent's status as such whether or not the Corporation would have the capacity to indemnify the agent against such liability under the provisions of this Article IX. Expenses incurred in defending any proceeding described in this Article IX may be advanced by the Corporation prior to the final disposition of such proceeding upon receipt of an undertaking by or on behalf of the agent to repay such amount, if it is ultimately determined that the agent is not entitled to be indemnified as authorized in this Article IX.

ARTICLE X

Miscellaneous

Section 1. Checks, Drafts, Etc.

All checks, drafts or other orders for payment of money, notes or other evidences of indebtedness, and any assignment or endorsement thereof, issued in the name or payable to the Corporation, shall be signed or endorsed by such person or persons and in such manner as, from time to time, shall be determined by resolution of the Board of Directors.

Section 2. Contracts, Etc. - How Executed.

The Board of Directors, except as otherwise provided in these Bylaws, may authorize any officer or officers, agent or agents, to enter into any contract or execute any instrument in the name of and on behalf of the Corporation, and such authority may be general or confined to specific instances.

Section 3. Certificates of Stock.

All certificates shall be signed in the name of the Corporation by the Chairman of the Board or the President or a Vice President and by the Treasurer or an assistant treasurer or the Secretary or an Assistant Secretary, certifying the number of shares and the class or series thereof owned by the shareholder. Any or all of the signatures on a certificate may be by facsimile signature. In case any officer, transfer agent or registrar who has signed or whose facsimile signature has been placed upon a certificate shall have ceased to be such officer, transfer agent or registrar before such certificate is issued, it may be issued by the Corporation with the same effect as if such person were an officer, transfer agent or registrar at the date of issue.

Section 4. Lost Certificates.

Except as provided in this section, no new certificate for shares shall be issued at any time. The Board of Directors may, in case any share certificate or certificate for any other security is lost, stolen or destroyed, authorize the issuance of a new certificate in lieu thereof, upon such terms and conditions as the Board may require, including provision for indemnification of the Corporation secured by a bond or other adequate security sufficient to protect the Corporation against any claim that may be made against it, including any expense or liability, on account of the alleged loss, theft or destruction of such certificate or the issuance of such new certificate.

Section 5. Representation of Shares of Other Corporations.

Any person designated by resolution of the Board of Directors or, in the absence of such designation, the Chairman of the Board, the President or any Vice President or the Secretary, or any other person authorized by any of the foregoing, is authorized to vote on behalf of the Corporation any and all shares of any other corporation or corporations, foreign or domestic, owned by the Corporation.

Section 6. Construction and Definitions.

Unless the context otherwise requires, the general provisions, rules of construction and definitions contained in the Corporations Code of the State of California shall govern the construction of these Bylaws.

ARTICLE XI

Amendments

Section 1. Amendment by Shareholders.

New Bylaws may be adopted or these Bylaws may be amended or repealed by the affirmative vote of a majority of the outstanding shares entitled to vote, except as otherwise provided by law or in the Articles of Incorporation.

Section 2. Amendment by Directors.

Subject to the rights of the shareholders as provided in Section 1 of this Article XI to adopt, amend or repeal Bylaws, and subject to the provisions of the Articles of Incorporation, Bylaws may be adopted, amended or repealed by the Board of Directors; provided, however, that the Board of Directors may not adopt a Bylaw amendment changing the authorized number of Directors without the consent of the shareholders.

SECRETARY'S CERTIFICATE

I, the undersigned, do hereby certify:

1. That I am the duly elected Secretary of Molina Healthcare, Inc., a California corporation.

2. That the foregoing Bylaws constitute the Bylaws of said corporation conformed to reflect an amendment duly adopted by the Board of Molina Healthcare, Inc., at the regularly scheduled board meeting held on December 14, 2000 and ratified by unanimous vote of the shareholders at the annual shareholder meeting held on December 18, 2000.

IN WITNESS WHEREOF, I have hereunto subscribed my name this 25th day of January, 2001.

/s/

Mark L. Andrews
Corporate Secretary

EXHIBIT 3.4

BYLAWS
OF
MOLINA HEALTHCARE, INC.,
a Delaware corporation

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BYLAWS
OF
MOLINA HEALTHCARE, INC.

ARTICLE I

OFFICES

Section 1.1. Registered Office. The registered office of the Corporation shall be maintained in the County of New Castle, State of Delaware, and the registered agent in charge thereof is The Corporation Trust Company.

Section 1.2. Other Offices. The Corporation may also have offices and keep the books and records of the Corporation, except as may otherwise be required by law, at such other places both within and outside the State of Delaware as the Board of Directors of the Corporation (the "Board of Directors") may from time to time determine or the business of the Corporation may require.

ARTICLE II

STOCKHOLDERS' MEETINGS

Section 2.1. Place of Meetings. All meetings of the stockholders, whether annual or special, shall be held at an office of the Corporation or at such other place, within or outside the State of Delaware, as may be fixed from time to time by the Board of Directors.

Section 2.2. Annual Meetings.

(a) An annual meeting of the stockholders shall be held on the [first Tuesday of April] each year commencing in the year 2003, but if such date is a legal holiday then on the next business day following, at One Golden Shore Drive, Long Beach, California 90802, at which such stockholders shall elect members to the Board of Directors and transact such other business as may properly be brought before such meeting. Nominations of persons for election to the Board of Directors of the Corporation and the proposal of business to be considered by the stockholders may be made at an annual meeting of stockholders (i) pursuant to the Corporation's notice of meeting of stockholders, (ii) by or at the direction of the Board of Directors or (iii) by any stockholder of the Corporation who was a stockholder of record at the time of giving of notice provided for in Section 2.2(b), who is entitled to vote at such meeting and who complied with the notice procedures set forth in Section 2.2(b).

(b) At an annual meeting of the stockholders, only such business as shall have been properly brought before such meeting shall be conducted. For

nominations or other business to be properly brought before an annual meeting by a stockholder pursuant to Section 2.2(c) of these Bylaws, (i) such stockholder must have given timely notice thereof in writing to the Secretary of the Corporation, (ii) such other business must be a proper matter for stockholder action under the General Corporation Law of the State of Delaware, (iii) if such stockholder, or the beneficial owner on whose behalf any such nomination or proposal is made, has provided the Corporation with a Solicitation Notice (as such term is hereinafter defined), such stockholder or beneficial owner must, in the case of a nomination or nominations, have delivered a proxy statement and form of proxy to holders of a percentage of the Corporation's voting shares reasonably believed by such stockholder or beneficial owner to be sufficient to elect the nominee or nominees proposed to be nominated by such stockholder, and must, in either case, have included in such materials the Solicitation Notice or, in the case of a proposal, have delivered a proxy statement and form of proxy to holders of at least the percentage of the Corporation's voting shares required under applicable law to carry any such proposal and (iv) if no Solicitation Notice relating thereto has been timely provided pursuant to this Section 2.2(b), the stockholder or beneficial owner proposing such nomination or business must not have solicited a number of proxies sufficient to have required the delivery of such a Solicitation Notice under this Section 2.2. To be timely, a stockholder's notice shall be delivered to the Secretary of the Corporation at the principal executive offices of the Corporation not later than the close of business on the ninetieth (90th) day nor earlier than the close of business on the one hundred twentieth (120th) day prior to the first anniversary of the preceding year's annual meeting of the stockholders; provided, however, that in the event that the date of the annual meeting is scheduled more than thirty (30) days prior to the anniversary of the preceding year's annual meeting, notice by the stockholder, to be timely, must be so delivered not earlier than the close of business on the one hundred twentieth (120th) day prior to such annual meeting and not later than the close of business on the later of the ninetieth (90th) day prior to such annual meeting or the tenth (10th) day following the day on which public announcement of the date of such meeting is first made. In no event shall the public announcement of an adjournment of an annual meeting of the stockholders commence a new time period for the giving of a stockholder's notice as described above. Such stockholder's notice in connection with an annual meeting shall set forth (A) as to each person that the stockholder proposes to nominate for election or reelection as a director all information relating to such person that is required to be disclosed in solicitations of proxies for the election of directors in an election contest or is otherwise required, in each case pursuant to Regulation 14A under the Securities Exchange Act of 1934, as amended (the "1934 Act") and Rule 14a-11 thereunder (including such person's written consent to being named in the proxy statement as a nominee and to serving as a director if elected), (B) as to any other business that such stockholder proposes to bring before the meeting, a brief description of the business desired to be brought before such meeting, the reasons for conducting such business at the meeting and any material interest in such business of such stockholder and the beneficial owner, if any, on whose behalf such proposal is made and (C) as to the stockholder giving the notice and the beneficial owner, if any, on whose behalf such stockholder's nomination or proposal is made (i) the name and address of such stockholder, as they appear on the Corporation's books, and of such beneficial owner, (ii) the class and number of shares of capital stock of the Corporation which are owned

beneficially and of record by such stockholder and such beneficial owner and (iii) whether either such stockholder or beneficial owner intends to deliver a proxy statement and form of proxy to holders of, in the case of a nomination or nominations, a sufficient number of holders of the Corporation's voting shares to elect such nominee or nominees or, in the case of the proposal, at least the percentage of the Corporation's voting shares required under applicable law to carry the proposal (an affirmative statement of such intent, a "Solicitation Notice").

(c) Notwithstanding anything in the second sentence of Section 2.2(b) of these Bylaws to the contrary, in the event that the number of directors to be elected to the Board of Directors of the Corporation is increased and there is no public announcement naming all of the nominees for director or specifying the size of the increased Board of Directors made by the Corporation at least one hundred (100) days prior to the first anniversary of the preceding year's annual meeting, a stockholder's notice required by this Section shall also be considered timely, but only with respect to nominees for any new positions created by such increase, if it shall be delivered to the Secretary at the principal executive offices of the Corporation not later than the close of business on the tenth (10th) day following the day on which such public announcement is first made by Corporation.

(d) Only persons who are nominated, accordance with the procedures set forth in this Section 2.2 shall be eligible to serve as directed only such business shall be conducted at a meeting of stockholders as shall have been brought before the meeting in accordance with the procedures set forth in this Section 2.2. Except as otherwise provided by law, the Chairman of the meeting shall have the power and duty to determine whether a nomination or any business proposed to be brought before the meeting was made, or proposed, as the case may be, in accordance with the procedures set forth in these Bylaws and, if any proposed nomination or business is not in compliance with these Bylaws, to declare that such defective proposal or nomination shall not be presented for stockholder action a the meeting and shall be disregarded.

(e) Notwithstanding the foregoing provisions of this Section 2.2, in order to include information with respect to a stockholder proposal in the proxy statement and form of proxy for a stockholders' meeting, stockholders must provide notice as required by the regulations promulgated under the 1934 Act. Nothing in these Bylaws shall be deemed to affect any rights of stockholders to request inclusion of proposals in the Corporation proxy statement pursuant to Rule 14a-8 under the 1934 Act.

(f) For purposes of this Section 2.2, "public announcement" shall mean disclosure in a press release reported by the Dow Jones News Service, Associated Press or comparable national news service or in a document publicly filed by the Corporation with the Securities and Exchange Commission pursuant to Section 13, 14 or 15(d) of the 1934 Act.

Section 2.3. Notice of Annual Meeting. Written notice of the annual meeting stating the place, date and hour of the meeting, shall be given not less than ten nor more

than sixty days before the date of the meeting to each stockholder entitled to vote at such meeting. If mailed, notice is given when deposited in the United States mail, postage prepaid, directed to the stockholder at his address as it appears on the records of the Corporation.

Section 2.4. Stockholders' List. At least ten (10) days before every meeting of stockholders, a complete list of the stockholders entitled to vote at said meeting, arranged in alphabetical order and showing the address of each stockholder and the number of shares registered in the name of each stockholder, shall be prepared by the Secretary. Such list shall be open to the examination of any stockholder, for any purpose germane to the meeting, during ordinary business hours, for a period of at least ten days prior to the meeting at the place where the meeting is to be held. The list shall also be produced and kept at the time and place of the meeting during the whole time thereof, and may be inspected by any stockholder who is present.

Section 2.5. Special Meetings.

(a) Pursuant to the Certificate of Incorporation, special meetings of the stockholders of the Corporation for any purpose or purposes may be called at any time by the President or Chief Executive Officer of the Corporation, the Chairperson of the Board of Directors, the Board of Directors or by a committee of the Board of Directors which has been duly designated by the Board of Directors and the powers and authority of which, as provided in a resolution of the Board of Directors or in the Bylaws of the Corporation, include the power to call such meetings. Such special meetings may not be called by any other person or persons.

(b) If a special meeting is properly called by any person or persons other than the Board of Directors, the request shall be in writing, specifying the general nature of the business proposed to be transacted, and shall be delivered personally or sent by registered mail or by telegraphic or other facsimile transmission to the Chairman of the Board of Directors the Chief Executive Officer, or the Secretary of the Corporation. No business may be transacted at such special meeting, otherwise than specified in such notice. The Board of Directors shall determine the time and place of such special meeting, which shall be held not less than thirty- five (35) nor more than one hundred twenty (120) days after the date of the receipt of the request. Upon determination of the time and place of the meeting, the officer receiving the request shall cause notice to be given to the stockholders entitled to vote, in accordance with the provisions of Section 2.6 of these Bylaws. If the notice is not given within one hundred (100) days after the receipt of the request, the person or persons properly requesting the meeting may set the time and place of the meeting and give the notice. Nothing contained in this paragraph (b) shall be construed as limiting, fixing, or affecting the time when a meeting of stockholders called by action of the Board of Directors may be held.

(c) Nominations of persons for election to the Board of Directors may be made at a special meeting of stockholders at which directors are to be elected pursuant to the Corporation's notice of meeting (i) by or at of the direction of the Board of

Directors or (ii) by any stockholder of the Corporation who is a stockholder of record at the time of giving notice provided for in these Bylaws who shall be entitled to vote at the meeting and who complies with the notice procedures set forth in this Section 2.5(c). In the event the Corporation calls a special meeting of stockholders for the purpose of electing one or more directors to the Board of Directors, any such stockholder may nominate a person or persons (as the case may be), for election to such position(s) as specified in the Corporation's notice of meeting, if the stockholder's notice required by Section 2.2(b) of these Bylaws shall be delivered to the Secretary at the principal executive offices of the Corporation not earlier than the close of business on the one hundred twentieth (120th) day prior to such special meeting and not later than the close of business on the later of the ninetieth (90th) day prior to such meeting or the tenth (10th) day following the day on which public announcement is first made of the date of the special meeting and of the nominees proposed by the Board of Directors to be elected at such meeting. In no event shall the public announcement of an adjournment of a special meeting commence a new time period for the giving of a stockholder's notice as described above.

Section 2.6. Notice of Special Meetings. Written notice of a special meeting, stating the place, date and hour of the meeting and the purpose or purposes for which the meeting is called, shall be given not less than ten nor more than sixty days before the date of the meeting to each stockholder entitled to vote at such meeting. If mailed, notice is given when deposited in the United States mail, postage prepaid, directed to the stockholder at his address as it appears on the records of the Corporation.

Section 2.7. Quorum; Adjournment. The holders of a majority of the shares issued and outstanding and entitled to vote thereat, present in person or represented by proxy, shall be requisite and shall constitute a quorum at all meetings of the stockholders for the transaction of business except as otherwise provided by statute, by the Certificate of Incorporation or by these Bylaws. If, however, such quorum shall not be present or represented at any meeting of the stockholders, the stockholders entitled to vote thereat, present in person or represented by proxy, shall have the power to adjourn the meeting from time to time, without notice other than announcement at the meeting, of the place, date and hour of the adjourned meeting, until a quorum shall again be present or represented by proxy. At the adjourned meeting at which a quorum shall be present or represented by proxy, the Corporation may transact any business which might have been transacted at the original meeting. If the adjournment is for more than thirty (30) days, or if after the adjournment, a new record date is fixed for the adjourned meeting, a notice of the adjourned meeting shall be given to each stockholder of record entitled to vote at the meeting. Shares of its own stock belonging to the Corporation or to another corporation, if a majority of the shares entitled to vote in the election of directors of such other corporation is held, directly or indirectly, by the Corporation, shall neither be entitled to vote nor be counted for quorum purposes; provided, however, that the foregoing shall not limit the right of the Corporation to vote stock, including, without limitation, its own stock, held by it in a fiduciary capacity.

Section 2.8. Order of Business. At each meeting of the stockholders, such business may be transacted as may be properly brought before such meeting, whether or not such business is stated in the notice of such meeting or in a waiver thereof, except as otherwise required by law or expressly provided therein. The order of business at the meetings of the stockholders shall be as determined by the Chairman of the Board.

Section 2.9. Voting. When a quorum is present at any meeting, and subject to the provisions of the General Corporation Law of the State of Delaware, the Certificate of Incorporation or by these Bylaws in respect of the vote that shall be required for a specified action, the vote of the holders of a majority of the shares having voting power, present in person or represented by proxy, shall decide any question brought before such meeting, unless the question is one upon which, by express provision of the statutes or of the Certificate of Incorporation or of these Bylaws, a different vote is required in which case such express provision shall govern and control the decision of such question. Each stockholder shall have one vote for each share of stock having voting power registered in his name on the books of the Corporation, except as otherwise provided in the Certificate of Incorporation.

Section 2.10. Proxies.

(a) Each stockholder entitled to vote at a meeting of stockholders or to express consent or dissent to corporate action in writing without a meeting may authorize another person or persons to act for him by proxy, but no such proxy shall be voted or acted upon after three years from its date, unless the proxy provides for a longer period.

(b) A stockholder may issue a valid proxy by (i) executing a written authorization therefor identifying the person or persons authorized to act for such stockholder by proxy or (ii) transmitting or authorizing the transmission of a telegram, cablegram or other means of electronic transmission, provided that the telegram, cablegram or other means of electronic transmission either sets forth or is submitted with information from which it can be determined that the telegram, cablegram or other electronic transmission was authorized by the stockholder. A copy, facsimile transmission or other reliable reproduction of a written or electronically-transmitted proxy authorized by this Section 2.10 may be substituted for or used in lieu of the original writing or electronic transmission. Each proxy shall be delivered to the inspectors of election prior to or at the meeting.

Section 2.11. Inspectors. Either the Board of Directors or, in the absence of designation of inspectors by the Board of Directors, the chairman of any meeting of the stockholders may, in its or such person's discretion, appoint two (2) or more inspectors to act at any meeting of the stockholders. Such inspectors shall perform such duties as shall be specified by the Board of Directors or the chairman of the meeting. Inspectors need not be Stockholders, employees, officers or directors of the Corporation. No director or nominee for the office of director shall be appointed as any such inspector.

ARTICLE III

DIRECTORS

Section 3.1. General Powers. The business and affairs of the Corporation shall be managed by or under the direction of the Board of Directors which may exercise all such powers of the Corporation and do all such acts and things as are not, by the General Corporation Law of the State of Delaware nor by the Certificate of Incorporation nor by these Bylaws, directed or required to be exercised or done by the stockholders.

Section 3.2. Number and Qualifications of Directors.

(a) The number of directors which shall constitute the whole Board of Directors shall be no less than seven and no more than eleven; provided that until changed by resolution of the Board of Directors, the number of directors shall be fixed at seven. With the exception of the first Board of Directors, which shall be elected by the Sole Incorporator, and except as provided in the Corporation's Certificate of Incorporation or in Section 3.3 of this Article III, the directors shall be elected at the annual meeting of the stockholders by a plurality vote of the shares represented in person or by proxy and each director elected shall hold office until his successor is elected and qualified unless he shall resign, become disqualified, disabled, or otherwise removed. Directors need not be stockholders.

(b) Each of the directors of the Corporation shall hold office until (i) the next annual meeting of the stockholders following such director's election and until such director's successor shall have been elected and qualified or (ii) his earlier death, resignation or removal in the manner that the directors of the Corporation other than those who may be elected pursuant to the terms of any series of Preferred Stock or any other securities of the Corporation other than Common Stock may determine from time to time. In accordance with the Certificate of Incorporation, the directors of the Corporation shall be classified, with respect to the time for which they hold office, into three classes containing three directors each: one class whose term expires at the first annual meeting of stockholders that is held after the first organizational meeting of the Board of Directors, another class whose term expires at the second annual meeting of stockholders that is held after the first organizational meeting of the Board of Directors and another class whose term expires at the third annual meeting of stockholders that is held after the first organizational meeting of the Board of Directors, with the directors in each class to hold office until their successors are elected and qualified. If the number of directors is changed by the Board of Directors, then any newly-created directorships or any decrease in directorships shall be so apportioned among the classes as to make all classes as nearly equal in number as possible; provided, however, that no decrease in the number of directors shall shorten the term of

any incumbent director. At each annual meeting of the stockholders, subject to the rights of the holders of any class or series of capital stock having a preference over Common Stock as to dividends or upon liquidation, the successors of the class of directors whose term expires at that meeting shall be elected to hold office for a term expiring at the annual meeting of stockholders held in the third (3rd) year following the year of their election.

Section 3.3. Vacancies; Resignation and Removal of Directors.

(a) If the office of any director or directors becomes vacant by reason of death, resignation, retirement, disqualification, removal from office, or otherwise, or a new directorship is created, the Board of Directors shall choose a successor or successors, or a director to fill the newly created directorship, who shall hold office for the unexpired term (in the case of a vacancy) or until the next election of directors (in the case of a new directorship).

(b) Any director of the Corporation may at any time resign by giving written notice to the Board of Directors, the Chairman of the Board, the President or the Secretary of the Corporation. Such resignation shall take effect upon receipt thereof by the Corporation, or such later time specified therein; and, unless otherwise specified therein, the acceptance of such resignation shall not be necessary to make it effective.

(c) Any director may be removed at any time only for cause by an affirmative vote of the holders of sixty-six and two-thirds percent (66-2/3%) of the shares then entitled to vote in the election of directors.

Section 3.4. Place of Meetings. The Board of Directors may hold its meetings inside or outside of the State of Delaware, at the office of the Corporation or at such other places as they may from time to time determine, or as shall be fixed in the respective notices or waivers of notice of such meetings.

Section 3.5. Compensation of Directors. Directors who are not at the time also a salaried officer or employee of the Corporation or any of its subsidiaries may receive such stated salary for their services and/or such fixed sums and expenses of attendance for attendance at each regular or special meeting of the Board of Directors as may be established by resolution of the Board; provided that nothing herein contained shall be construed to preclude any director from serving the Corporation in any other capacity and receiving compensation therefor. Members of special or standing committees may be allowed like compensation for attending committee meetings. Each director, whether or not a salaried officer or employee of the Corporation or any of its subsidiaries, shall be entitled to receive from the Corporation reimbursement for the reasonable expenses incurred by such person in connection with the performance of such person's duties as a director.

Section 3.6. Regular Meetings. Regular meetings of the Board of Directors shall be held at such times and places as the Board shall from time to time by resolution determine, except that the annual meeting of the Board to elect officers of the Corporation

for the ensuing year shall be held within ten (10) days after the annual meeting of stockholders. If any day fixed for a regular meeting shall be a legal holiday under the laws of the place where the meeting is to be held, then the meeting which would otherwise be held on that day shall be held at the same hour on the next succeeding business day.

Section 3.7. Special Meetings. Special meetings of the Board of Directors may be held at any time on the call of the President or at the request in writing of a majority of the directors. Notice of any such meeting, unless waived, shall be given to directors personally, by telephone, by first-class United States mail, postage prepaid or by facsimile transmission to each director at his or her address as the same appears on the records of the Corporation not less than two days prior to the day on which such meeting is to be held if such notice is delivered personally, by telephone or by facsimile transmission, and not less than four days prior to the day on which the meeting is to be held if such notice is by first-class United States mail. If the Secretary shall fail or refuse to give such notice, then the notice may be given by the officer or any one of the directors calling the meeting. Any such meeting may be held at such place as the Board may fix from time to time or as may be specified or fixed in such notice or waiver thereof. Any meeting of the Board of Directors shall be a legal meeting without any notice thereof having been given, if all the directors shall be present thereat, and no notice of a meeting shall be required to be given to any director who shall attend such meeting.

Section 3.8. Action Without Meeting; Use of Communications Equipment.

(a) Any action required or permitted to be taken at any meeting of the Board of Directors or any committee thereof may be taken without a meeting, if a written consent to such action is signed by all members of the Board or of such committee, as the case may be, and such written consent is filed with the minutes of proceedings of the Board of Directors.

(b) Members of the Board of Directors, or any committee designated by the Board, may participate in a meeting of the Board or committee by means of conference telephone or similar communications equipment by means of which all persons participating in the meeting can hear each other, and participation in a meeting pursuant to this section shall constitute presence in person at such meeting.

Section 3.9. Quorum and Manner of Acting.

(a) Except as otherwise provided in these Bylaws, a majority of the total number of directors as at the time specified by the Bylaws shall constitute a quorum at any regular or special meeting of the Board of Directors. Except as otherwise provided by statute, by the Certificate of Incorporation or by these Bylaws, the vote of a majority of the directors present at any meeting at which a quorum is present shall be the act of the Board of Directors. In the absence of a quorum, a majority of the directors present may adjourn the meeting from time to time until a quorum shall be present. Notice of any adjourned meeting need not be given, except that notice shall be given to all

directors if the adjournment is for more than thirty days or if after the adjournment a new record date is fixed for the adjourned meeting.

(b) The Board of Directors may adopt such rules and regulations not inconsistent with the provisions of these Bylaws for the conduct of its meetings and management of the affairs of the Corporation as the Board may deem to be proper. In the absence of the Chairman of the Board, such person designated by the Board shall preside at Board meetings.

ARTICLE IV

EXECUTIVE AND OTHER COMMITTEES

Section 4.1. Executive Committee. The Board of Directors may, by resolution adopted by a majority of the entire Board of Directors, designate annually three (3) or more of the directors to constitute members or alternate members of an Executive Committee, which Executive Committee shall have and may exercise, between the meetings of the Board of Directors, all of the powers and authority of the Board of Directors in the management of the business and affairs of the Corporation, including, without limitation, if such Executive Committee is so empowered and authorized by resolution adopted by a majority of the entire Board of Directors, the power and authority to declare a dividend and to authorize the issuance of stock, and may authorize the seal of the Corporation to be affixed to all papers which may require it, except that such Executive Committee shall not have such power or authority in reference to:

(a) amending the Certificate of Incorporation;

(b) adopting an agreement of merger or consolidation involving the Corporation;

(c) recommending to the stockholders the sale, lease or exchange of all or substantially all of the property and assets of the Corporation;

(d) recommending to the stockholders a dissolution of the Corporation or a revocation of a dissolution;

(e) taking any action related to the approval or determination of any matter in connection with any business combination;

(f) filling vacancies on the Board of Directors or on any committee of the Board of Directors, including, but not limited to, the Executive Committee; or

(g) amending or repealing any resolution of the Board of Directors which by its terms may be amended or repealed only by the Board of Directors.

The Board of Directors shall have the power at any time to change the membership of the Executive Committee, to fill all vacancies in it and to discharge it, either with or without cause.

Section 4.2. Other Committees. The Board of Directors may, by resolution adopted by a majority of the entire Board of Directors (except to the extent prohibited by law), designate from among the directors one or more other committees, each of which shall have such authority of the Board of Directors as may be specified in the resolution of the Board of Directors designating such committee; provided that no committee shall have the power or authority in reference to the matters described in Section 4.1(a) through 4.1(g) above. A majority of all of the members of such committee may determine its action and fix the time and place of its meetings, unless the Board of Directors shall otherwise provide. The Board of Directors shall have the power at any time to change the membership of, to fill all vacancies in and to discharge any such committee, either with or without cause. The committees shall keep regular minutes of their proceedings and report the same to the Board of Directors when required.

Section 4.3. Procedure; Meeting; Quorum. Regular meetings of the Executive Committee or of any other committee of the Board of Directors, of which no notice shall be necessary, may be held at such times and places as shall be fixed by resolution adopted by a majority of the members thereof. Special meetings of the Executive Committee or any other committee of the Board of Directors shall be called at the request of any member thereof. Notice of each special meeting of the Executive Committee or of any other committee of the Board of Directors shall be delivered personally, by telephone, by first-class United States mail, postage prepaid or by facsimile transmission to each member thereof not later than one day prior to the day on which such meeting is to be held if such notice is delivered personally, by telephone or by facsimile transmission and not less than four days prior to the day on which such meeting is to be held if such notice is delivered by first-class United States mail; provided, however, that notice of any such special meeting need not be given to any such member who shall, either before or after such special meeting, submit a signed waiver of such notice or who shall attend such meeting without protesting, prior to or at its commencement, the lack of such notice to such member. Any special meeting of the Executive Committee or any other committee of the Board of Directors shall be a valid meeting without any notice thereof having been given if all of the members thereof shall be present thereat. Notice of any adjourned meeting of any committee of the Board of Directors need not be given. Each of the Executive Committee and each other committee of the Board of Directors may adopt such rules and regulations that are not inconsistent with the provisions of law, the Certificate of Incorporation or these Bylaws for the conduct of its meetings as the Executive Committee or each other committee of the Board of Directors, as the case may be, may deem to be proper. A majority of the members of the Executive Committee or of any other committee of the Board of Directors shall constitute a quorum for the transaction of business at any meeting thereof, and the vote of a majority of the members thereof present at any meeting thereof at which such a quorum is present shall be the act of the Executive Committee or such other committee, as the case may be. Each of the Executive Committee and each other committee of the Board of Directors shall keep

written minutes of its proceedings and shall report on such proceedings to the Board of Directors.

ARTICLE V

OFFICERS

Section 5.1. Executive Officers. The executive officers of the Corporation shall be a President, such number of Executive Vice Presidents, if any, as the Board of Directors may determine, a Secretary and a Treasurer. One person may hold any number of said offices.

Section 5.2. Election, Term of Office and Eligibility. The executive officers of the Corporation shall be elected annually by the Board of Directors at its annual meeting; provided that new or additional officers may be elected at any meeting of the Board. Each officer, except such officers as may be appointed in accordance with the provisions of Section 5.3, shall hold office until the next annual election of officers or until his death, resignation or removal. The Chairman of the Board shall be and remain a member of the Board of Directors. None of the other officers need be members of the Board.

Section 5.3. Subordinate Officers. The Board of Directors may appoint a Controller, such Vice Presidents, Assistant Secretaries, Assistant Treasurers and such other officers, and such agents as the Board may determine, to hold office for such period and with such authority and to perform such duties as the Board may from time to time determine. The Board may, by specific resolution, empower the chief executive officer of the Corporation or the Executive Committee to appoint any such subordinate officers or agents.

Section 5.4. Removal. The President, any Executive Vice President, the Secretary and/or the Treasurer may be removed at any time, either with or without cause, but only by the affirmative vote of the majority of the total number of directors as at the time specified by the Bylaws. Any subordinate officer appointed pursuant to Section 5.3 may be removed at any time, either with or without cause, by the majority vote of the directors present at any meeting of the Board or by any committee or officer empowered to appoint such subordinate officers.

Section 5.5. Chairman of the Board. The Chairman of the Board shall, if present, preside at meetings of the Board of Directors and, if present, preside at meetings of the stockholders.

Section 5.6. The President. The President shall be the chief executive officer of the Corporation. He shall have executive authority to see that all orders and resolutions of the Board of Directors are carried into effect and, subject to the control vested in the Board of Directors by statute, by the Certificate of Incorporation, or by these

Bylaws, shall administer and be responsible for the management of the business and affairs of the Corporation. He shall preside at all meetings of the stockholders and the Board of Directors; and in general shall perform all duties incident to the office of the President and such other duties as from time to time may be assigned to him by the Board of Directors.

Section 5.7. The Executive Vice Presidents. In the event of the absence or disability of the President, each Executive Vice President, in the order designated, or in the absence of any designation, then in the order of their election, shall perform the duties of the President. The Executive Vice Presidents shall also perform such other duties as from time to time may be assigned to them by the Board of Directors or by the chief executive officer of the Corporation.

Section 5.8. The Secretary. The Secretary shall:

(a) Keep the minutes of the meetings of the stockholders and of the Board of Directors;

(b) See that all notices are duly given in accordance with the provisions of these Bylaws or as required by law;

(c) Be custodian of the records and of the seal of the Corporation and see that the seal or a facsimile or equivalent thereof is affixed to or reproduced on all documents, the execution of which on behalf of the Corporation under its seal is duly authorized;

(d) Have charge of the stock record books of the Corporation;

(e) In general, perform all duties incident to the office of Secretary, and such other duties as are provided by these Bylaws and as from time to time are assigned to him by the Board of Directors or by the chief executive officer of the Corporation.

Section 5.9. The Treasurer. The Treasurer shall:

(a) Receive and be responsible for all funds of and securities owned or held by the Corporation and, in connection therewith, among other things: keep or cause to be kept full and accurate records and accounts for the Corporation; deposit or cause to be deposited to the credit of the Corporation all moneys, funds and securities so received in such bank or other depositary as the Board of Directors or an officer designated by the Board may from time to time establish; and disburse or supervise the disbursement of the funds of the Corporation as may be properly authorized.

(b) Render to the Board of Directors at any meeting thereof, or from time to time when ever the Board of Directors or the chief executive officer of the Corporation may require, financial and other appropriate reports on the condition of the Corporation;

(c) In general, perform all the duties incident to the office of Treasurer and such other duties as from time to time may be assigned to him by the Board of Directors or by the chief executive officer of the Corporation.

Section 5.10. Salaries. The salaries of the officers shall be fixed from time to time by the Board of Directors, and no officer shall be prevented from receiving such salary by reason of the fact that he is also a director of the Corporation.

Section 5.11. Delegation of Duties. In case of the absence of any officer of the Corporation or for any other reason which may seem sufficient to the Board of Directors, the Board of Directors may, for the time being, delegate his powers and duties, or any of them, to any other officer or to any director.

ARTICLE VI

SHARES OF STOCK

Section 6.1. Regulation. Subject to the terms of any contract of the Corporation, the Board of Directors may make such rules and regulations as it may deem expedient concerning the issue, transfer, and registration of certificates for shares of the stock of the Corporation, including the issue of new certificates for lost, stolen or destroyed certificates, and including the appointment of transfer agents and registrars.

Section 6.2. Stock Certificates. Certificates for shares of the stock of the Corporation shall be respectively numbered serially for each class of stock, or series thereof, as they are issued, shall be impressed with the corporate seal or a facsimile thereof, and shall be signed by the President or a Vice President, and by the Secretary or Treasurer, or an Assistant Secretary or an Assistant Treasurer, provided that such signatures may be facsimiles on any certificate countersigned by a transfer agent other than the Corporation or its employee. Each certificate shall exhibit the name of the Corporation, the class (or series of any class) and number of shares represented thereby, and the name of the holder. Each certificate shall be otherwise in such form as may be prescribed by the Board of Directors.

Section 6.3. Restriction on Transfer of Securities. A restriction on the transfer or registration of transfer of securities of the Corporation may be imposed either by the Certificate of Incorporation or by these Bylaws or by an agreement among any number of security holders or among such holders and the Corporation. No restriction so imposed shall be binding with respect to securities issued prior to the adoption of the

restriction unless the holders of the securities are parties to an agreement or voted in favor of the restriction.

A restriction on the transfer of securities of the Corporation is permitted by this Section if it:

(a) Obligates the holder of the restricted securities to offer to the Corporation or to any other holders of securities of the Corporation or to any other person or to any combination of the foregoing a prior opportunity, to be exercised within a reasonable time, to acquire the restricted securities; or

(b) Obligates the Corporation or any holder of securities of the Corporation or any other person or any combination of the foregoing to purchase the securities which are the subject of an agreement respecting the purchase and sale of the restricted securities; or

(c) Requires the Corporation or the holders of any class of securities of the Corporation to consent to any proposed transfer of the restricted securities or to approve the proposed transferee of the restricted securities; or

(d) Prohibits the transfer of the restricted securities to designated persons or classes of persons; and such designation is not manifestly unreasonable; or

(e) Restricts transfer or registration of transfer in any other lawful manner.

Unless noted conspicuously on the security, a restriction, even though permitted by this Section, is ineffective except against a person with actual knowledge of the restriction.

Section 6.4. Transfer of Shares. Subject to the restrictions permitted by Section 6.3, shares of the capital stock of the Corporation shall be transferable on the books of the Corporation by the holder thereof in person or by his duly authorized attorney, upon the surrender or cancellation of a certificate or certificates for a like number of shares. As against the Corporation, a transfer of shares can be made only on the books of the Corporation and in the manner hereinabove provided, and the Corporation shall be entitled to treat the registered holder of any share as the owner thereof and shall not be bound to recognize any equitable or other claim to or interest in such share on the part of any other person, whether or not it shall have express or other notice thereof, save as expressly provided by the statutes of the State of Delaware.

Section 6.5. Fixing Date for Determination of Stockholders of Record.

(a) In order that the Corporation may determine the stockholders entitled to notice of or to vote at any meeting of stockholders or any adjournment thereof, the Board of Directors may fix a record date, which record date shall not precede the date upon which the resolution fixing the record date is adopted by the Board of Directors, and which record date shall not be more than sixty (60) nor less than ten (10) days before the date of such meeting. If no record is fixed by the Board of Directors, the record date for determining stockholders entitled to notice of or to vote at a meeting of stockholders shall be at the close of business on the day next preceding the day on which notice is given, or, if notice is waived, at the close of business on the day next preceding the day on which the meeting is held. A determination of stockholders of record entitled to notice of or to vote at a meeting of stockholders shall apply to any adjournment of the meeting; providing, however, that the Board of Directors may fix a new record date for the adjourned meeting.

(b) In order that the Corporation may determine the stockholders entitled to receive payment of any dividend or other distribution or allotment of any rights or the stockholders entitled to exercise any rights in respect of any change, conversion or exchange of stock, or for the purpose of any other lawful action, the Board of Directors may fix a record date, which record date shall not precede the date upon which the resolution fixing the record date is adopted, and which record date shall be not more than sixty days prior to such action. If no record date is fixed, the record date for determining stockholders for any such purpose shall be at the close of business on the day on which the Board of Directors adopts the resolution relating thereto.

Section 6.6. Lost Certificate. Any stockholder claiming that a certificate representing shares of stock has been lost, stolen or destroyed may make an affidavit or affirmation of the fact and, if the Board of Directors so requires, advertise the same in a manner designated by the Board, and give the Corporation a bond of indemnity in form and with security for an amount satisfactory to the Board (or an officer or officers designated by the Board), whereupon a new certificate may be issued of the same tenor and representing the same number, class and/or series of shares as were represented by the certificate alleged to have been lost, stolen or destroyed.

ARTICLE VII

BOOKS AND RECORDS

Section 7.1. Location. The books, accounts and records of the Corporation may be kept at such place or places within or outside the State of Delaware as the Board of Directors may from time to time determine.

Section 7.2. Inspection. The books, accounts, and records of the Corporation shall be open to inspection by any member of the Board of Directors at all times; and open to inspection by the stockholders at such times, and subject to such regulations as the Board of Directors may prescribe, except as otherwise provided by statute.

Section 7.3. Corporate Seal. The corporate seal shall contain two concentric circles between which shall be the name of the Corporation and the word "Delaware" and in the center shall be inscribed the words "Corporate Seal."

ARTICLE VIII

DIVIDENDS AND RESERVES

Section 8.1. Dividends. The Board of Directors of the Corporation, subject to any restrictions contained in the Certificate of Incorporation and other lawful commitments of the Corporation, may declare and pay dividends upon the shares of its capital stock either out of the surplus of the Corporation, as defined in and computed in accordance with the General Corporation Law of the State of Delaware, or in case there shall be no such surplus, out of the net profits of the Corporation for the fiscal year in which the dividend is declared and/or the preceding fiscal year. If the capital of the Corporation, computed in accordance with the General Corporation Law of the State of Delaware, shall have been diminished by depreciation in the value of its property, or by losses, or otherwise, to an amount less than the aggregate amount of the capital represented by the issued and outstanding stock of all classes having a preference upon the distribution of assets, the Board of Directors of the Corporation shall not declare and pay out of such net profits any dividends upon any shares of any classes of its capital stock until the deficiency in the amount of capital represented by the issued and outstanding stock of all classes having a preference upon the distribution of assets shall have been repaired.

Section 8.2. Reserves. The Board of Directors of the Corporation may set apart, out of any of the funds of the Corporation available for dividends, a reserve or reserves for any proper purpose and may abolish any such reserve.

ARTICLE IX

MISCELLANEOUS PROVISIONS

Section 9.1. Fiscal Year. The fiscal year of the Corporation shall end on the 31st day of December of each year.

Section 9.2. Depositories. The Board of Directors or an officer designated by the Board shall appoint banks, trust companies, or other depositories in which shall be deposited from time to time the money or securities of the Corporation.

Section 9.3. Checks, Drafts and Notes. All checks, drafts, or other orders for the payment of money and all notes or other evidences of indebtedness issued in the name of the Corporation shall be signed by such officer or officers or agent or agents as

shall from time to time be designated by resolution of the Board of Directors or by an officer appointed by the Board.

Section 9.4. Contracts and Other Instruments. The Board of Directors may authorize any officer or agent to enter into any contract or execute and deliver any instrument in the name and on behalf of the Corporation and such authority may be general or confined to specific instances.

Section 9.5. Notices. In addition to other means of notice permitted herein, whenever under the provisions of the statutes or of the Certificate of Incorporation or of these Bylaws notice is required to be given to any director or stockholder, it shall not be construed to mean personal notice, but such notice may be given in writing, by mail, by depositing the same in a post office or letter box, in a postpaid sealed wrapper, or by delivery to a telegraph company, addressed to such director or stockholder at such address as appears on the records of the Corporation, or, in default of other address, to such director or stockholder at the General Post Office in the City of Dover, Delaware, and such notice shall be deemed to be given at the time when the same shall be thus mailed or delivered to a telegraph company.

Section 9.6. Waivers of Notice. Whenever any notice is required to be given under the provisions of the statutes or of the Certificate of Incorporation or of these Bylaws, a waiver thereof in writing signed by the person or persons entitled to said notice, whether before or after the time stated therein, shall be deemed equivalent to notice. Attendance of a person at a meeting shall constitute a waiver of notice of such meeting, except when the person attends a meeting for the express purpose of objecting, at the beginning of the meeting, to the transaction of any business because the meeting is not lawfully called or convened. Neither the business to be transacted at, nor the purpose of, any regular or special meeting of the stockholders, directors or members of a committee of directors need be specified in any written waiver of notice.

Section 9.7. Stock in Other Corporations. Any shares of stock in any other Corporation which may from time to time be held by this Corporation may be represented and voted at any meeting of shareholders of such Corporation by the President or a Vice President, or by any other person or persons thereunto authorized by the Board of Directors, or by any proxy designated by written instrument of appointment executed in the name of this Corporation by its President or a Vice President. Shares of stock belonging to the Corporation need not stand in the name of the Corporation, but may be held for the benefit of the Corporation in the individual name of the Treasurer or of any other nominee designated for the purpose by the Board of Directors. Certificates for shares so held for the benefit of the Corporation shall be endorsed in blank or have proper stock powers attached so that said certificates are at all times in due form for transfer, and shall be held for safekeeping in such manner as shall be determined from time to time by the Board of Directors.

Section 9.8. Indemnification.

(a) The Corporation shall indemnify any person who was or is a party or is threatened to be made a party to, or is otherwise involved in, any threatened, pending or completed action, suit or proceeding, whether civil, criminal, administrative or investigative, by reason of the fact that such person is or was a director or an officer of the Corporation, against all judgments, fines, amounts paid in settlement and other liability and loss suffered, and all expenses (including, without limitation, attorneys' fees) reasonably incurred thereby in connection with such action, suit or proceeding to the fullest extent permitted by the General Corporation Law of the State of Delaware and any other applicable law as from time to time in effect. Such right of indemnification shall not be deemed to be exclusive of any rights to which any such director or officer may otherwise be entitled. The foregoing provisions of this Section 9.8(a) shall be deemed to be a contract between the Corporation and each director and officer of the Corporation serving in such capacity at any time while this Section 9.8(a) is in effect, and any repeal or modification thereof shall not affect any right or obligation then existing with respect to any state of facts then or theretofore existing or any action, suit or proceeding theretofore or thereafter brought or threatened based in whole or in part upon any such state of facts.

(b) The Corporation shall indemnify any person who was or is a party or is threatened to be made a party to, or is otherwise involved in, any threatened, pending or completed action, suit or proceeding, whether civil, criminal, administrative or investigative, by reason of the fact that such person is or was an employee or agent of the Corporation, or is or was serving at the request of the Corporation as a director, officer, employee or agent of another Corporation, partnership, joint venture, trust or other enterprise, against all judgments, fines, amounts paid in settlement and other liability and loss suffered, and all expenses (including, without limitation, attorneys' fees) reasonably incurred thereby in connection with such action, suit or proceeding to the extent permitted by and in the manner set forth in and permitted by the General Corporation Law of the State of Delaware and any other applicable law as from time to time in effect. Such right of indemnification shall not be deemed to be exclusive of any other rights to which any such person may otherwise be entitled.

(c) If a claim under subsection (a) or (b) of this Section is not paid in full by the Corporation within thirty days after a written claim has been received by the Corporation, the claimant may at any time thereafter bring suit against the Corporation to recover the unpaid amount of the claim and, if successful in whole or in part, the claimant shall also be entitled to be paid the expense of prosecuting such claim. It shall be a defense to any action (other than an action brought to enforce a claim for expenses incurred in defending any proceeding in advance of its final disposition where the required undertaking has been tendered to the Corporation) that the claimant has failed to meet a standard of conduct which makes it permissible under Delaware law for the Corporation to indemnify the claimant for the amount claimed, but the burden of proving such defense shall be on the Corporation. Neither the failure of the Corporation (including its Board of Directors, independent legal counsel, or its stockholders) to have made a determination prior to the commencement of such action that indemnification of the claimant is permissible in the circumstances because he has met such standard of conduct, nor an actual determination by the Corporation (including its Board of Directors, independent legal

counsel, or its stockholders) that the claimant has not met such standard of conduct, nor the termination of any proceeding by judgment, order, settlement, conviction or upon a plea of nolo contendere or its equivalent, shall be a defense to the action or create a presumption that the claimant has failed to meet the required standard of conduct.

(d) The right to indemnification and the payment of expenses incurred in defending a proceeding in advance of its final disposition conferred in this Section shall not be exclusive of any other right which any person may have or hereafter acquire under any statute, provision of the Certificate of Incorporation, bylaw, agreement, vote of stockholders or disinterested directors or otherwise.

(e) The Corporation may maintain insurance, at its expense, to protect itself and any director, officer, employee or agent of the Corporation or another Corporation, partnership, joint venture, trust or other enterprise against any expense, liability or loss, whether or not the Corporation would have the power to indemnify such person against such expense, liability or loss under Delaware law.

(f) To the extent that any director, officer, employee or agent of the Corporation is by reason of such position, or a position with another entity at the request of the Corporation, a witness in any proceeding, he shall be indemnified against all costs and expenses actually and reasonably incurred by him or on his behalf in connection therewith.

(g) Any amendment, repeal or modification of any provision of this Section by the stockholders or the directors of the Corporation shall not adversely affect any right or protection of a director or officer of the Corporation existing at the time of such amendment, repeal or modification.

Section 9.9. Amendment of Bylaws.

(a) The stockholders, by the affirmative vote of the holders of a majority of the stock issued and outstanding and having voting power may, at any annual or special meeting if notice of such alteration or amendment of the Bylaws is contained in the notice of such meeting, adopt, amend, or repeal these Bylaws, and alterations or amendments of Bylaws made by the stockholders shall not be altered or amended by the Board of Directors.

(b) The Board of Directors, by the affirmative vote of a majority of the whole Board, may adopt, amend, or repeal these Bylaws at any meeting, except as provided in the above paragraph. Bylaws made by the Board of Directors may be altered or repealed by the stockholders.

* * * * *

EXHIBIT 10.1

STATE OF CALIFORNIA

STANDARD AGREEMENT -- APPROVED BY THE ATTORNEY GENERAL
STD.2(REV.5-91)

CONTRACT NUMBER 95-23637
AM. NO.
TAXPAYER'S FEDERAL EMPLOYER IDENTIFICATION NO. 33-0342719

THIS AGREEMENT, made and entered into this 2nd day of April, 1996 in the State of California, by and between State of California, through its duly elected or appointed, qualified and acting

TITLE OF OFFICER ACTING FOR STATE
Chief, Program Support Branch

AGENCY
Department of Health Services, hereafter called the State, and

CONTRACTOR'S NAME
Molina Medical Centers, hereafter called the Contract:

WTTNESSETH: That the Contractor for and in consideration of the covenants, conditions, agreements, and stipulations of the State hereinafter express does hereby agree to furnish to the State services and materials as follows: (Set forth service to be rendered by Contractor, amount to be paid Contract time for performance or completion, and attach plans and specifications, if any.)

ARTICLE 1 - PREAMBLE

This Contract is entered into under the provisions of Section 14087.3, Welfare and Institutions (W&I) Code.

WHERE AS, it is the best interest of all parties to enter into this Contract,

NOW THEREFORE, this contract is amended as follows:

[SEAL]

CONTINUED ON 125 SHEETS, EACH BEARING NAME OF CONTRACTOR AND CONTRACT NUMBER.

The provisions on the reverse side hereof constitute a part of this agreement. IN WITNESS WHEREOF, this agreement has been executed by the parties hereto, upon the date first above written.

STATE OF CALIFORNIA	CONTRACTOR
AGENCY Department of Health Service	CONTRACTOR (If other than an individual, state whether a corporation, partnership, etc.) Molina Medical Centers
BY (AUTHORIZED SIGNATURE) /s/	BY (AUTHORIZED SIGNATURE) /s/
PRINTED NAME OF PERSON SIGNING Edward E. Stahlberg	PRINTED NAME AND TITLE OF PERSON SIGNING John Molina, J.D. - Chief Administrative Officer
TITLE Chief, Program Support Branch	ADDRESS One Golden Shore, Long Beach, CA 90802

AMOUNT ENCUMBERED	PROGRAM/CATEGORY (CODE AND TITLE)		FUND TITLE		Department of General Services Use Only
AMOUNT ENCUMBERED BY THIS DOCUMENT $ 32,080,630	Section 14157 W&I Code		Care Deposit		Exempt From PCC per W&I Code 14087.4
PRIOR AMOUNT ENCUMBERED FOR THIS CONTRACT $ -0-	(OPTIONAL USE) Federal Cat. 93778 4260-101-001 & 890		50% Fed & 50% State		
	ITEM 4260-601-912	CHAPTER 303	STATUTE 1995	FISCAL YEAR 1995-96	
TOTAL AMOUNT ENCUMBERED TO $ 32,080,630	OBJECT OF EXPENDITURE (CODE AND TITLE) N/A				
I hereby certify upon my own personal knowledge that budgeted funds are available for the period and purpose of the expenditure stated above.	T.B.A. NO.	B.R. NO.			
SIGNATURE OF ACCOUNTING OFFICER /s/		DATE 4/2/96			

[ ] CONTRACTOR [ ] STATE AGENCY [ ] DEPT. OF GEN. SER. [ ] CONTROLLER [ ]

1. The Contractor agrees to indemnify, defend and save harmless the State, its officers, agents and employees from any and all claims and losses accruing or resulting to any and all contractors, subcontracters materialmen, laborers and any other person, firm or corporation furnishing or supplying work services, materials or supplies in connection with the performance of this contract, and from any and all claims losses accruing or resulting to any person, firm or corporation who may be injured or damaged by Contractor in the performance of this contract

2. The Contractor, and the agents and employees of Contractor, in the performance of the agreement, shall act in an independent capacity and not as officers or employees or agents of State of California.

3. The State may terminate this agreement and be relieved of the payment of any consideration to Contractor should Contractor fail to perform the covenants herein contained at the time and in the manner herein provided. In the event of such termination the State may proceed with the work in any manner deemed proper by the State. The cost to the State shall be deducted from any sum due the Contractor under this agreement, and the balance, if any, shall be paid the Contractor upon demand.

4. Without the written consent of the State, this agreement is not assignable by Contractor either in whole or in part.

5. Time is of the essence in this agreement.

6. No alteration or variation of the terms of this contract shall be valid unless made in writing and signed the parties hereto, and no oral understanding or agreement not incorporated herein, shall be binding on any of the parties hereto.

7. The consideration to be paid Contractor, as provided herein, shall be in compensation for all of Contractor's expenses incurred in the performance hereof, including travel and per diem, unless otherwise expressly so provided.

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ARTICLE II - DEFINITIONS

As used in this Contract, unless otherwise expressly provided or the context otherwise requires, the following definitions of terms will govern the construction of this Contract:

A. Administrative Costs means only those costs which arise out of the operation of the plan excluding direct and overhead costs incurred in the furnishing of health care services which would ordinarily be incurred in the provision of these services whether or not through a plan.

B. Affiliate means an organization or person that directly, or indirectly through one or more intermediaries controls or is controlled by, or is under control with the Contractor and that provides services to or receives services from the Contractor.

C. Allied Health Personnel means specially trained, licensed, or credentialed health workers other than Physicians, podiatrists and Nurses.

D. Ambulatory Care means the type of health services that are provided on an outpatient basis. While many inpatients may be ambulatory, the term, "Ambulatory Care" usually implies that the Member has come to a location such as a clinic, health center, or Physician's office to receive services and has departed the same day.

E. Beneficiary Identification Card (BIC) means a permanent plastic card issued by the State to recipients of entitlement programs which is used by contractors to verify health plan eligibility. Files are updated monthly.

F. California Children Services (CCS) means those services authorized by the CCS program for the diagnosis and treatment of the CCS eligible conditions of a specific Member.

G. California Children Services (CCS) Eligible Conditions means a physically handicapping condition defined in Title 22, CCR, Section 41800.

H. California Children Services (CCS) Program means the public health program which assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of 21 years who have CCS eligible conditions.

I. Claims and Eligibility Real-Time System (CERTS) means the mechanism for verifying a recipient's Medi-Cal or County Medical Services Program (CMSP) eligibility by computer.

J. Confidential Information means specific facts or documents identified as "confidential" by either law, regulations or contractual language.

K. Contract means this written agreement between DHS and the Contractor.

L. Contracting Providers means a Physician, Nurse, technician, teacher, researcher, hospital, home health agency, nursing home, or any other individual or institution that contracts with a health plan to provide medical services to plan Members.

M. Corrective Actions means specific identifiable activities or undertakings of the Contractor which address program deficiencies or problems identified by formal audits or DHS monitoring activities.

N. County Department means the County Department of Social Services (DSS), or other county agency responsible for determining the initial and continued eligibility for the Medi-Cal program.

O. Covered Services means those services set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301, and Title 17, CCR, Chapter 4, Subchapter 13, Article 4, beginning with Section 6840. Covered Services do not include:

1. Services for major organ transplants as specified in Section 6.7.2.1.

2. Long term care services as specified in Section 6.7.2.3.

3. Home and community based services as specified in Section 6.7.3.8

4. California Children Services (CCS) as specified in Section 6.7.3.2.

5. Mental health services as specified in Section 6.7.3.3.

6. Alcohol and drug treatment services as specified in Section 6.7.3.4.

7. Fabrication of optical lenses as specified in Section 6.7.3.6.

8. Direct observed treatment for tuberculosis as specified in Section 6.7.3.7.

9. Dental services as specified in Title 22, CCR, Section 51307.

10. Acupuncture services as specified in Title 22, CCR, Section 51308.5.

11. Chiropractic services as specified in Title 22, CCR, Section 51308.

12. Prayer or spiritual healing as specified in Title 22, CCR, Section 51312.

13. Local Education Agency (LEA) assessment services as specified in Title 22, CCR, Section 51360(b)(l) provided to a Member who qualifies for LEA services based on Title 22, CCR, Section 51190.1(a).

14. Any LEA services as specified in Title 22, CCR, Section 51360 provided pursuant to an Individualized Education Plan (IEP) as set forth in Education Code, Section 56340 et seq. or an Individualized Family Service Plan (IFSP) as set forth in Government Code Section 95020.

15. Laboratory services provided under the State serum alphafetoprotein testing program administered by the Genetic Disease Branch of DHS.

P. Credentialing means the recognition of professional or technical competence. The process involved may include registration, certification, licensure and professional association membership.

Q. DOC means the State Department of Corporations which is responsible for administering the Knox-Keene Act of 1975.

R. DMH means the Department of Mental Health, the State agency, in consultation with the California Mental Health Directors Association (CMHDA) and California Mental Health Planning Council, which sets policy and administers for the delivery of community based public mental health services statewide.

S. DHS means the Department of Health Services single State Department responsible for administration of the Medi-Cal, CMSP, CCS, GHPP, CHDP, and other health related programs.

T. DHHS means the Department of Health and Human Services, the federal agency responsible for management of the Medicaid program.

U. Dietitian/Nutritionist means a person who is registered or eligible for registration as a Registered Dietitian by the Commission on Dietetic Registration (Business and Professions Code, Chapter 5.65, Sections 2585 and 2586).

V. Director means the Director of the State of California Department of Health Services.

W. Disproportionate Share Hospital (DSH) means a health Facility licensed pursuant to Chapter 2, Division 2, Health and Safety Code, to provide acute inpatient hospital services, which is eligible to receive payment adjustments from the State pursuant to W&I Code, Section 14105.98.

X. Eligible Beneficiary means any Medi-Cal beneficiary who is residing in the Contractor's Service Area with one of the following aid codes: Aid to Families with Dependent Children - aid codes 30,32,33,35,38,39,3A,3C,40, 42,4C,54,59,3P,3R; Medically Needy Family - aid code 34; Public Assistance Aged - aid codes 10,16,18; Medically Needy Aged - aid code 14; Public Assistance Blind - aid codes 20,26,28,6A; Medically Needy Blind - aid code 24; Public Assistance Disabled - aid codes 36,60,66,68,6C; Medically Needy Disabled - aid code 64; Medically Indigent Child - aid codes 03,04,4K,5K, 45,82; Medically Indigent Adult - aid code 86; and Refugees - aid codes 01,02, and 08, with the following exclusions:

1. Individuals who have been approved by the Medi-Cal Field Office or the California Children Services Program for bone marrow, heart, heart-lung, liver, lung, combined liver and kidney, or combined liver and small bowel transplants.

2. Individuals who elect and are accepted to participate in the following Medi-Cal waiver programs: In-Home Medical Care Waiver Program, the Skilled Nursing Facility Waiver Program, the Model Waiver Program, the Acquired Immune Deficiency (AIDS) and AIDS Related Conditions Waiver Program, and the Multipurpose Senior Services Waiver Program.

3. Individuals determined by the Medi-Cal Field Office to be in need of long term care and residing in a Skilled Nursing Facility (SNF) for 30 days past the month of admission.

Y. Emergency Conditions means those medical conditions requiring immediate medical care to avoid disability or death.

Z. Emergency Services means those health services required for alleviation of severe pain or immediate diagnosis and treatment of unforeseen medical conditions, which if not immediately diagnosed and treated, could lead to disability or death.

AA. Encounter means a single "face-to-face" visit or medically related service rendered by (a) provider(s) in an Ambulatory Care setting to a Member enrolled in the health plan during the date of service. It includes, but not limited to, all services for which the Contractor incurred any financial liability.

BB. Enrollment means the process by which an Eligible Beneficiary becomes a Member of the Contractor's plan.

CC. Facility means any premise that is:

1. Owned, leased, used or operated directly or indirectly by or for the Contractor or its Affiliates for purposes related to this Contract or

2. Maintained by a provider to provide services on behalf of the Contractor.

DD. Federal Financial Participation means federal expenditures provided to match proper State expenditures made under approved State Medicaid plans.

EE. Federally Qualified HMO means a prepaid health delivery plan that has fulfilled the requirements of the HMO Act, along with its amendments and regulations, and has obtained the Federal Government's qualification status under Section 1310(d) of the Public Health Service Act (42 USC S300e).

FF. Fee-For-Service (FFS) means a method of charging based upon billing for a specific number of units of services rendered to an Eligible Beneficiary. Fee-For-Service is the traditional method of reimbursement used by Physicians and payment almost always occurs retrospectively (i.e., after the service has been rendered).

GG. Fee-For-Service Mental Health Services (FFS/MC) means the mental health services covered through Fee-For-Service Medi-Cal which include outpatient services and acute care inpatient services. These services are provided through Primary Care Physicians as well as psychiatrists and psychologists.

HH. Financial Security means cash or cash equivalents which are immediately redeemable upon demand by DHS, in an amount determined by DHS, which shall not be less than one full month's capitation. This is required when prepayment of capitation is agreed upon by DHS and the Contractor.

II. Financial Statements means the Financial Statements as defined by Generally Accepted Accounting Principles (GAAP) which includes a Balance Sheet, Income Statement, Statement of Cash Flows, Statement of Equity and accompanying footnotes. All documents are prepared in accordance with GAAP.

JJ. Fiscal Year (FY) means any 12-month period for which annual accounts are kept. The State Fiscal Year is July 1 through June 30, the federal Fiscal Year is October 1 through September 30.

KK. Grievance means a complaint filed by either a Member or a provider.

LL. Health Maintenance Organization (HMO) means an organization that, through a coordinated system of health care, provides or assures the delivery of an agreed upon set of comprehensive health maintenance and treatment services for an enrolled group of persons through a predetermined periodic fixed prepayment.

MM. Indian Health Service (IHS) Facilities means Facilities operated with funds from the IHS under the Indian Self-Determination Act and the Indian Health Care Improvement Act, through which services are provided, directly or by contract, to the eligible Indian population within a defined geographic area.

NN. Intermediate Care Facility (ICF) means a Facility which is licensed as an ICF by DHS or a hospital or Skilled Nursing Facility which meets the standards specified in Title 22, CCR, Section 51212 and has been certified by DHS for participation in the Medi-Cal program.

OO. Joint Commission On Accreditation of Hospitals (JCAHO) means the composition of representatives of the American Hospital Association, American Medical Association, American College of Physicians and American College of Surgeons, JCAHO establishes guidelines for the operation of hospitals and other health Facilities and accreditation programs.

PP. Knox-Keene Health Care Service Plan Act of 1975 means the law which regulates HMOs and is administrated by the Department of Corporations (DOC), commencing with Section 1340, Health & Safety Code.

QQ. Local Authority means a health care organization in which local stakeholders share governance responsibility for administrating Medi-Cal managed care.

RR. Marketing means any activity conducted on behalf of the Contractor where information regarding the services offered by the Contractor is disseminated in order to persuade Eligible Beneficiaries to enroll. Marketing also includes any similar activity to secure the endorsement of any individual or organization on behalf of the Contractor.

SS. Marketing Organization means any subcontractor or entity who agrees to provide Marketing services for the Contractor.

TT. Marketing Representative means a person who is engaged in Marketing activities on behalf of the Contractor either through direct employment by the Contractor or through a Marketing Organization.

UU. Medi-Cal Eligibility Data System (MEDS) means the automated eligibility information processing system operated by the State which provides on-line access for recipient information, update of recipient eligibility data and on-line printing of immediate need beneficiary identification cards. The MEDS also produces Beneficiary Identification Cards (BIC) and maintains data on federal SSI/SSP and Medicare buy-in beneficiaries.

VV. Medical Case Management Services means services provided by a Primary Care Provider to ensure the coordination of Medically Necessary health care services, assuring the provision of preventive services in accordance with established standards and periodicity schedules and ensuring continuity of care for Medi-Cal enrollees. It includes health risk assessment, treatment planning, coordination, referral, follow-up, and monitoring of appropriate services and resources required to meet an individual's health care needs.

WW. Medical Records means written documentary evidence of treatments rendered to plan Members.

XX. Medically Necessary means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.

YY. Member means any Eligible Beneficiary who has enrolled in the Contractor's plan.

ZZ. Minor Consent Services means those treatment services of a sensitive nature for which minors do not need parental consent to access. Such services include pregnancy, abortion, mental health services.

A1. Newborn Child means a child born to a Member during her membership or the month prior to her membership.

B1. Non-Emergency Medical Transportation means inclusion of services outlined in Title 22, CCR, Sections 51231.1 and 51231.2 rendered by licensed providers.

C1. Non-Medical Transportation means transportation of Members to medical services by passenger car, taxicabs, or other forms of public or private conveyances provided by persons not registered as Medi-Cal providers. Does not include the transportation of sick, injured, invalid, convalescent, infirm, or otherwise incapacitated Members by ambulances, litter vans, or wheelchair vans licensed, operated and equipped in accordance with state and local statutes, ordinances or regulations.

D1. Non-Physician Medical Practitioners (Mid-Level Practitioner) means a nurse practitioner, certified nurse midwife, or physician assistant authorized to provide Primary Care under Physician supervision.

E1. Nurse means a person licensed by the California Board of Nursing as, at least, a Registered Nurse (RN).

F1. Outpatient Care means treatment provided to an Member who is not confined in a health care Facility. Outpatient care is associated with treatment in a hospital that does not necessitate an overnight stay, e.g., emergency treatment.

G1. Pediatric Subacute Care means health care services needed by a person under 21 years of age who uses a medical technology that compensates for the loss of vital bodily function. Medical necessity criteria are described in the Physician's Manual of Criteria for Medi-Cal Authorization.

H1. Physician means a person duly licensed as a Physician by the Medical Board of California.

I1. Policy Letter means a document which has been dated, numbered and issued by the Medi-Cal Managed Care Division. It clarifies regulatory or contractual requirements.

J1. Prepaid Person means a person entitled to receive health care services from the Contractor in consideration of a predetermined periodic, fixed subscription premium, or capitation payment.

K1. Preventive Care means health care designed to prevent disease and /or its consequences. There are three levels of Preventive Care; primary, such as immunizations, aimed at preventing disease; secondary, such as disease screening programs, aimed at early detection of disease; and tertiary, such as physical therapy, aimed at restoring function after the disease has occurred.

L1. Primary Care means a basic level of health care usually rendered in ambulatory settings by general practitioners, family practitioners, internists, obstetricians, pediatricians, and mid-level practitioners. This type of care emphasizes caring for the Member's general health needs as opposed to specialists focusing on specific needs.

M1. Primary Care Physician means a Physician responsible for supervising, coordinating, and providing initial and Primary Care to patients; for initiating referrals for specialist care; and for maintaining the continuity of patient care. A Primary Care Physician has focused the delivery of medicine to general practice or is a board certified or board eligible internist, pediatrician, obstetrician/gynecologist, or family practitioner.

N1. Primary Care Provider means a person responsible for supervising, coordinating, and providing initial and Primary Care to Members; for initiating referrals and for maintaining the continuity of Member care. A Primary Care Provider may be a Primary Care Physician or non-physician medical practitioner.

O1. Prior Authorization means the process by which contractors approve, usually in advance of the rendering, requested medical services. This is part of the Utilization management system.

P1. Prior Authorization Request means a method by which practitioners seek approval from Contractor to render medical services. The Contractor's Utilization Review (UR) Coordinator is responsible for granting approval to providing specific, non-emergency medical services in advance of rendering such services.

Q1. Quality Assurance (QA) means a formal set of activities to assure the quality of clinical and non-clinical services provided. Quality Assurance includes quality assessment and Corrective Actions taken to remedy any deficiencies identified through the assessment process. Comprehensive Quality Assurance includes mechanisms to assess and assure the quality of both health services and administrative and support services.

R1. Quality Improvement (QI) means the result of an effective QA program, which objectively and systematically monitors and evaluates the quality and appropriateness of care and services to Members through Quality of Care studies and other health related activities.

S1. Quality Improvement Plan (QIP) means consisting of systematic activities to monitor and evaluate the medical care delivered to Members according to the standards set forth in regulations and Contract language. The plan must have processes in place which measure the effectiveness of care, identify problems, and implement improvement on a continuing basis.

T1. Quality of Care means the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

U1. Quality Indicators means the referral to measurable variables relating to a specific clinic or health services delivery area which are reviewed over a period of time to screen delivered health care and to monitor the process or outcome of care delivered in that clinical area.

V1. Sensitive Services means those services related to:

1. Sexual Assault

2. Drug or alcohol abuse for children 12 years of age or older.

3. Pregnancy

4. Family Planning

5. Sexually transmitted diseases designated by the Director for children 12 years of age or older.

W1. Service Area means the geographic area comprised of those areas designated by the U.S. Postal Service ZIP Codes that have been proposed by the Contractor and approved in writing by DHS.

X1. Service Location means any location at which a Member obtains any health care service provided by the Contractor under the terms of this Contract.

Y1. Service Site means the location designated by the Contractor at which Members shall receive Primary Care Physician services.

Z1. Short-Doyle Medi-Cal Mental Health Services (SD/MC) means as defined in Title 22, CCR, Section 51341, SD/MC Mental Health Services include: crisis intervention, crisis sterilization, inpatient hospital services, crisis residential treatment case management, adult residential treatment, day treatment intensive, rehabilitation, outpatient therapy, medication and support services.

A2. Short-Doyle Program means as defined in Title 22, CCR, Section 51341, the program administered by the Department of Mental Health to provide community mental health services and the program administered by the Department of Alcohol and Drug Programs to provide drug and alcohol treatment services.

B2. Skilled Nursing Facility (SNF) means, as defined in Title 22, CCR, Section 51121(a), any institution, place, building, or agency which is licensed as a Skilled Nursing Facility by DHS or is a distinct part or unit of a hospital, meets the standard specified in Section 51215 of these regulations (except that the distinct part of a hospital does not need to be licensed as a Skilled Nursing Facility) and has been certified by DHS for participation as a Skilled Nursing Facility in the Medi-Cal program. Section 51121(b) further defines the term "Skilled Nursing Facility" as including terms "skilled nursing home", "convalescent hospital", "nursing home", or "nursing Facility".

C2. State means the State of California.

D2. Subacute Care means, as defined in Title 22, CCR, Section 51124.5, a level of care needed by a patient who does not require hospital acute care but who requires more intensive licensed skilled nursing care than is provided to the majority of patients in a Skilled Nursing Facility (SNF).

E2. Subcontract means a written agreement entered into by the Contractor with any of the following:

1. A provider of health care services who agrees to furnish Covered Services to Members.

2. A Marketing Organization.

3. Any other organization or person(s) who agree(s) to perform any administrative function or service for the Contractor specifically related to fulfilling the Contractor's obligations to DHS under the terms of this Contract.

F2. Sub-Subcontractor means party to an agreement with a subcontractor descending from and subordinate to a Subcontract, which is entered into for the purpose of providing any goods or services connected with the obligations under this Contract.

G2. Supplemental Security Income (SSI) means the program authorized by Title XVI of the Social Security Act for aged, blind, and disabled persons.

H2. Third Party Liability (TPL) means the responsibility of persons other than the Contractor or the Member for payment of claims for injuries or trauma sustained by Members. This may be contractual, a legal obligation or as a result of or the fault or negligence of third parties (e.g., auto accidents or other personal injury casualty claims or work compensation appeals). DHS is responsible for follow up and collection of Third Party Liability payments where it has paid for related care.

I2. Urgent Care means services required to prevent serious deterioration of health following the onset of an unforeseen condition or injury (i.e., sore throats, fever, minor lacerations, and some broken bones).

J2. Utilization means the rate patterns of service usage or types of service occurring within a specified time. Inpatient Utilization is generally expressed in rates per unit of population-at-risk for a given period; e.g., the number of hospital admissions per 1,000 persons enrolled in an HMO/per year.

K2. Utilization Review means the process of evaluating the necessity, appropriateness, and efficiency of the use of medical services, procedures and Facilities.

ARTICLE III - GENERAL TERMS AND CONDITIONS

3.1 DELEGATION OF AUTHORITY

DHS intends to implement this Contract through a single administrator, called the "Contracting Officer". The Contracting Officer will be appointed by the Director of DHS. The Contracting Officer, on behalf of DHS, will make all determinations and take all actions as are appropriate under this Contract, subject to the limitations of applicable federal and State laws and regulations. The Contracting Officer may delegate his/her authority to act to an authorized representative through written notice to the Contractor.

The Contractor will designate a single administrator, hereafter called the "Contractor's Representative". The Contractor's Representative, on behalf of the Contractor, will make all determinations and take all actions as are appropriate to implement this Contract, subject to the limitations of the Contract, federal and State laws and regulations. The Contractor's Representative may delegate his/her authority to act to an authorized representative through written notice to the Contracting Officer. The Contractor's Representative will be empowered to legally bind the Contractor to all agreements reached with DHS.

The Contractor's Represention will be designated in writing by the Contractor. Such designation will be submitted to the Contracting Officer in accordance with Section 3.3, Authority of the State.

3.2 GOVERNING AUTHORITIES

This Contract will be governed and construed in accordance with:

Chapter 7 and 8 (commencing with Section 14000), Part 3, Division 9, W&I Code;

Division 3, Title 22, CCR;

Health and Safety Code Section 1340 et seq.

Title 10, CCR, Section 1300 et seq.

Title 42, Code of Federal Regulations (CFR);

Title 42, United States Code, Section 1396 et seq.;

Title 45, CFR, Part 74;

Subchapter 13 (commencing with Section 6800), Chapter 4, Part 1, Title 17, CCR, and;

All other applicable laws and regulations.

Any provision of this Contract which is in conflict with the above laws, regulations and federal Medicaid statutes is hereby amended to conform to the provisions of those laws and regulations. Such amendment of the Contract will be effective on the effective date of the statutes or regulations necessitating it, and will be binding on the parties even though such amendment may not have been reduced to writing and formally agreed upon and executed by the parties.

This amendment will constitute grounds for termination of this Contract in accordance with the provisions of Section 3.17.1, Termination by the State, and 3.17.2, Termination by the Contractor. The parties will be bound by the terms of the amendment until the effective date of the termination.

3.3 AUTHORITY OF THE STATE

A. Sole authority to establish, define, or determine the reasonableness, the necessity and level and scope of covered benefits under the Medi-Cal Managed Care program administered in this Contract or coverage for such benefits, or the eligibility of the beneficiaries or providers to participate in the Medi-Cal Managed Care Program reside with DHS.

B. Sole authority to establish or interpret policy and its application related to the above areas will reside with DHS.

C. The Contractor may not make any limitations, exclusions, or changes in benefits or benefit coverage; any changes in definition or interpretation of benefits; or any changes in the administration of the Contract related to the scope of benefits, allowable coverage for those benefits, or eligibility of beneficiaries or providers to participate in the program, without the express, written direction or approval of the Contracting Officer.

3.4 FULFILLMENT OF OBLIGATIONS

No covenant, condition, duty, obligation, or undertaking continued or made a part of this Contract will be waived except by written agreement of the parties hereto, and forbearance or indulgence in any other form or manner by either party in any regard

whatsoever will not constitute a waiver of the covenant, condition, duty, obligation, or undertaking to be kept, performed or discharged by the party to which the same may apply; and, until performance or satisfaction of all covenants, conditions, duties, obligations, and undertakings is complete, the other party will have the right to invoke any remedy available under this contract, or under law, notwithstanding such forbearance or indulgence.

3.5 COMPLIANCE WITH PROTOCOLS

The Contractor will develop and comply with all protocols and procedures within 30 days of their approval by DHS. All subsequent revisions thereof will be approved by DHS and implemented by the Contractor within 30 days of such approval. The Contractor will not implement protocols, procedures or revisions thereof prior to approval by DHS.

3.6 EQUAL OPPORTUNITY EMPLOYER

The Contractor will, in all solicitations or advertisements for employees placed by or on behalf of the Contractor, state that it is an equal opportunity employer, and will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding, a notice to be provided by DHS, advising the labor union or workers' representative of the Contract's commitments as an equal opportunity employer and will post copies of the notice in conspicuous places available to employees and applicants for employment.

3.7 NONDISCRIMINATION CLAUSE COMPLIANCE

A. During the performance of this Contract, Contractor and its subcontractors will not unlawfully discriminate, harass, or allow harassment, against any employee or applicant for employment because of sex, race, color, ancestry, religious creed, national origin, physical disability (including HIV and AIDS), mental disability, medical condition (including Cancer), age (over 40), marital status, and denial of family care leave. Contractors and subcontractors will insure that the evaluation and treatment of their employees and applicants for employment are free from discrimination and harassment. Contractor and subcontractors will comply with the provisions of the Fair Employment and Housing Act (Government Code, Section 12900 et seq.) and the applicable regulations promulgated thereunder (California Code of Regulations, Title 2, Section 7285.0 et seq.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code, Section 12990 (a-f), set forth in Chapter 5 of Division 4 of Title 2 of the California Code of Regulations are incorporated into this Contract by reference and made a part

hereof as if set forth in full. Contractor and its subcontractors will give notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreement.

B. The Contractor will include the nondiscrimination and compliance provisions of this clause in all Subcontracts to perform work under this Contract.

3.8 DISCRIMINATION PROHIBITION

The Contractor will not discriminate against Members or Eligible Beneficiaries because of race, color, creed, religion, ancestry, marital status, sexual orientation, national origin, age, sex, or physical or mental handicap in accordance with Title VI of the Civil Rights Act of 1964, 42 USC Section 2000d, rules and regulations promulgated pursuant thereto, or as otherwise provided by law or regulations. For the purpose of this Contract discriminations on the grounds of race, color, creed, religion, ancestry, age, sex, national origin, marital status, sexual orientation, or physical or mental handicap include but are not limited to the following: denying any Member any Covered Services or availability of a Facility; providing to a Member any Covered Service which is different, or is provided in a different manner or at a different time from that provided to other Members under this Contract except where medically indicated; subjecting a Member to segregation or separate treatment in any manner related to the receipt of any Covered Service; restricting a Member in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any Covered Service, treating a Member or Eligible Beneficiary differently from others in determining whether he or she satisfies any admission, Enrollment, quota, eligibility, membership, or other requirement or condition which individuals must meet in order to be provided any Covered Service; the assignment of times or places for the provision of services on the basis of the race, color, creed, religion, age, sex, national origin, ancestry, marital status, sexual orientation, or the physical or mental handicap of the participants to be served. The Contractor will take affirmative action to ensure that Members are provided Covered Services without regard to race, color, creed, religion, sex, national origin, ancestry, marital status, sexual orientation, or physical or mental handicap, except where medically indicated. For the purposes of this section, physical handicap includes the carrying of a gene which may, under some circumstances, be associated with disability in that person's offspring, but which causes no adverse effects on the carrier. Such genes will include, but are not limited to, Tay-Sachs trait, sickle cell trait, thalassemia trait, and X-linked hemophilia.

3.9 DISCRIMINATION COMPLAINTS

The Contractor agrees that copies of all Grievances alleging discrimination against Members or Eligible Beneficiaries because of race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual orientation, or physical or mental handicap will be forwarded to DHS for review and appropriate action.

3.10 MEMBERSHIP DIVERSITY

The Contractor agrees to serve a population broadly representative of the various age, social, and income groups within the Service Area, and that less than 75 percent (75 %) of its Prepaid Person population is of individuals receiving benefits under Title XVIII, Social Security Act, and individuals receiving benefits under Title XIX, Social Security Act (Section 1903(m), SSA).

DHS on request of the Contractor will apply to the Secretary, United States Department of Health and Human Services (DHHS) for a waiver of the 75 percent (75%) requirement, based on good cause. If that waiver is granted, then the 75 percent (75%) requirement under this Contract is waived as of the effective date of that federal waiver and for the time period granted by the waiver.

3.11 INSPECTION RIGHTS

The Contractor will allow DHS, DHHS, the Comptroller General of the United States, Department of Justice, (DOJ), Bureau of Medi-Cal Fraud, Department of Corporations (DOC) and other authorized state agencies, or their duly authorized representatives, to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services performed under this Contract, and to inspect, evaluate, and audit any and all books, records, and Facilities maintained by the Contractor and subcontractors pertaining to these services at any time during normal business hours. Books and records include, but are not limited to, all physical records originated or prepared pursuant to the performance under this Contract including working papers, reports, financial records, and books of account, Medical Records, prescription files, Subcontracts, and any other documentation pertaining to medical and nonmedical services for Members. Upon request, at any time during the period of this Contract, the Contractor will furnish any record, or copy of it, to DHS or DHHS.

3.12 NOTICES

All notices to be given under this Contract will be in writing and will be deemed to have been given when mailed to DHS or the Contractor:

State Department of Health Services
Medi-Cal Managed Care Division
714 P Street, Room 650
P.O. Box 942732
Sacramento, CA 94234-7320
Attn: Contracting Officer

John Molina, J.D.
Chief Administrative Officer
Molina Medical Centers, Inc.
One Golden Shore
Long Beach, CA 90802

3.13 CONTRACTOR'S NATIONAL LABOR RELATIONS BOARD (NLRB) DECLARATION

The Contractor, by signing this agreement, does swear under penalty of perjury that, no more than one final unappealable finding of contempt of court by a federal court has been issued against Contractor within the immediately preceding two-year period because of the Contractor's failure to comply with an order of a federal court which orders the Contractor to comply with an order of the NLRB.

3.14 TERM

The Contract will become effective April 2, 1996 and will continue in full force and effect through March 31, 2002 subject to the provisions of Article V, Sections 5.2 and 5.10 because the State has currently appropriated and available for encumbrance only funds to cover costs through June 30, 1996.

The term of the Contract consists of the following three periods: 1) The Implementation Period will extend from April 2, 1996; 2) The Operations Period will extend from October 2, 1996, subject to the termination provisions of Section 3.17, Termination and subject to the limitation provisions of Article V, Payment Provisions Section 5.2; and 3) The Turnover/Phaseout Period will extend from October 1, 2001 through March 31, 2002, subject to the provisions of Section 3.15, Contract Extension, in which case the Turnover/Phaseout Period will apply to the six (6) month period beginning the first day after the end of the Operations Period of the extension.

The Operations Period will commence subject to DHS acceptance of the Contractor's readiness to begin the Operations Period.

3.15 CONTRACT EXTENSION

DHS will have the exclusive option to extend the term of the Contract during the last twelve (12) months of the Contract, as determined by the original termination date or by a new termination date if an extension option has been exercised. DHS may invoke up to three (3) separate extensions of one (1) year each. The Contractor will be given at least nine (9) months prior written notice of DHS' decision on whether or not it will exercise this option to extend the Contract.

The Contractor will notify DHS of its intent to accept or reject the extension within five (5) State working days of the receipt of the notice from DHS.

3.16 TURNOVER AND PHASEOUT REQUIREMENTS

DHS will withhold an amount equal to 10% or one million dollars ($1,000,000), whichever is greater unless provided otherwise by the Financial Security agreement, from the capitation payment of the last month of the Operations Period until all activities required during the Turnover and Phaseout Period are completed.

If all Turnover and Phaseout activities are completed by the end of the Turnover and Phaseout Period, the withhold will be paid to the Contractor. If the Contractor fails to meet any requirement(s) by the end of the Turnover and Phaseout Period, DHS will deduct the costs of the remaining activities proportionately from the withhold amount and continue to withhold payment until all activities are completed.

3.16.1 OBJECTIVES FOR TURNOVER AND PHASEOUT PERIOD

The objective of the Turnover Period is to ensure that, at the termination of this Contract, the orderly transfer of necessary data and history records is made from the Contractor to DHS or to a successor Contractor. The orderly transfer is to ensure the continuity of access and Quality of Care to Members.

The objective of the Phaseout Period is to ensure that, at the termination of this Contract, the Contractor completes any and all of its remaining contractual obligations under the Contract.

Given the uncertainties associated with the Turnover and Phaseout Periods that will occur at the end of this Contract, the Contractor will be flexible to changing requirements.

If DHS exercises its option(s) to extend this Contract, all Turnover and Phaseout activities will be delayed a commensurate period of time.

3.16.2 TURNOVER REQUIREMENTS

Prior to the termination or expiration of this Contract and upon request by DHS, the Contractor will assist DHS in the orderly transfer of Member medical care. In doing this, the Contractor will make available to DHS copies of Medical Records, patient files, and any other pertinent information, including information maintained by any subcontractor, necessary for efficient case management of Members, as determined by the Director. Costs of reproduction will be borne by DHS. In no circumstances will a Medi-Cal Member be billed for this service.

3.16.3 PHASEOUT REQUIREMENTS

Phaseout for this Contract will consist of the processing, payment and monetary reconciliation(s) necessary regarding claims for payment for Covered Services.

Phaseout for the Contract will consist of the resolution of all financial and reporting obligations of the Contractor. The Contractor will remain liable for the processing and payment of invoices and other claims for payment for Covered Services and other services provided to Members pursuant to this Contract prior to the expiration or termination. The Contractor will submit to DHS all reports required in Article VI, Scope of Work, for the period from the last submitted report through the expiration or termination date.

All data and information provided by the Contractor will be accompanied by letter, signed by the responsible authority, certifying, under penalty of perjury, to the accuracy and completeness of the materials supplied.

3.16.4 TURNOVER AND PHASEOUT PERIOD

Turnover and Phaseout Periods will occur during the same six (6) month time period and this period will commence on the date the Operations Period of the Contract or Contract extension ends. Turnover and Phaseout related activities are non-payable items.

3.17 TERMINATION

3.17.1 TERMINATION - STATE OR DIRECTOR

DHS may terminate performance of work under this Contract in whole, or in part, whenever for any reason DHS determines that the termination is in the best interest of the State.

Notification will be given at least nine (9) months prior to the effective date of termination, except in cases where the Director determines the health and welfare of Members is jeopardized by continuation of this Contract, in which case the Contract will be immediately terminated. Notification will state the effective date of, and the reason for, the termination.

In addition to other grounds for termination, failure to comply with any of the terms of this Contract will constitute cause for termination.

3.17.2 TERMINATION - CONTRACTOR

If mutual agreement between DHS and the Contractor cannot be attained on capitation rates for rate years subsequent to September 30, 1997, the Contractor will retain the right to terminate the Contract, no earlier than September 30, 1998, by giving at least nine (9) months written notice to DHS to that effect. The effective date of any termination under this section will be September 30.

Grounds for contract termination by a Contractor are limited to its unwillingness to accept the capitation rates determined by DHS, or if DHS decides to negotiate rates, there is a failure to reach mutual agreement on rates.

3.17.3 MANDATORY TERMINATION

DHS will terminate this Contract in the event that: (1) the Secretary, DHHS, determines that the Contractor does not meet the requirements for participation in the Medicaid program, Title XIX of the Social Security Act, or (2) the Department of Corporations finds that the Contractor no longer qualifies for licensure under the Knox-Keene Health Care Service Plan Act by giving written notice to the Contractor. Notification will be given by DHS at least sixty (60) days prior to the effective date of termination, except in cases where the Director determines the health and welfare of Members is jeopardized by continuation of the Contract, in which case the Contract will be immediately terminated. Notification will state the effective date of, and the reason for, the termination.

Under these circumstances, termination of the Operations period will be effective on the last day of the month in which the Secretary, DHHS, or DOC makes such determination, provided that DHS provides the Contractor with at least 60 days notice of termination. The termination of this Contract will be effective on the last day of the second full month from the date of the notice of termination. The Contractor agrees that 60 days notice is reasonable. Termination under this section does not relieve the Contractor of its obligations under the Turnover and Phaseout Requirements, Sections 3.16.2 and 3.16.3.

3.17.4 TERMINATION OF OBLIGATIONS

All obligations to provide Covered Services under this Contract or Contract extension will automatically terminate on the date the Operations Period ends.

3.17.5 NOTICE TO MEMBERS OF TRANSFER OF CARE

No later than sixty (60) days prior to the termination or expiration of the Contract, DHS will notify Members about their medical benefits and available options.

3.18 SANCTIONS

In the event DHS finds Contractor non-compliant with the standards and requirements prescribed in this Contract, DHS will have the power and authority to impose sanctions provided in Welfare and Institutions Code, Section 14304 and Title 22, CCR, Section 53350. In addition, DHS may require the following:

The Contractor to ensure providers or subcontractors cease activities which include, but are not limited to, referrals, assignment of beneficiaries, and reporting, until new activities are approved by DHS and the Contractor is again in compliance.

3.19 LIQUIDATED DAMAGES PROVISIONS

3.19.1 GENERAL

It is agreed by the State and Contractor that:

A. If Contractor does not provide or perform the requirements of this Contract or applicable laws and regulations, damage to the State will result;

B. Proving such damages will be costly, difficult, and time-consuming;

C. Should the State choose to impose liquidated damages, the Contractor will pay the State those damages for not providing or performing the specified requirements;

D. Additional damages may occur in specified areas by prolonged periods in which Contractor does not provide or perform requirements;

E. The damage figures listed below represent a good faith effort to quantify the range of harm that could reasonably be anticipated at the time of the making of the Contract;

F. DHS may, at its discretion, offset liquidated damages from capitation payments owed to the Contractor;

G. Imposition of liquidated damages as specified in Sections 3.19.2, 3.19.3, and 3.19.4 will follow the administrative processes described below;

H. DHS will provide the Contractor with written notice specifying the Contractor requirement(s), contained in the Contract or as required by federal and State law or regulation, not provided or performed;

I. During the Implementation Period, the Contractor will submit or complete the outstanding requirement(s) specified in the written notice within five (5) State working days from the date of the notice, unless, subject to the Contracting Officer's written approval, the Contractor submits a written request for an extension. The request must include the following: the requirement(s) requiring an extension; the reason for the delay; and the proposed date of the submission of the requirement;

J. During the Implementation Period, if the Contractor has not performed or completed an Implementation Period requirement or secured an extension for the submission of the outstanding requirement, DHS may impose liquidated damages for the amount specified in Section 3.19.2;

K. During the Operations Period, the Contractor will demonstrate the provision or performance of the Contractor's requirement(s) specified in the written notice within a thirty (30) calendar day Corrective Action period from the date of the notice, unless a request for an extension is submitted to the Contracting Officer, subject to DHS' approval, within five (5) days from the end of the Corrective Action period. If Contractor has not demonstrated the provision or performance of the Contractor's requirement(s) specified in the written notice during the Corrective Action period, DHS may impose liquidated damages for each day the specified Contractor's requirement is not performed or provided for the amount specified in Section 3.19.3.

L. During the Operations Period, if the Contractor has not performed or provided the Contractor's requirement(s) specified in the written notice or secured the written approval for an extension, after thirty (30) days from the first day of the imposition of liquidated damages, DHS will notify the Contractor in writing of the increase of the liquidated damages to the amount specified in Section 3.19.3.

Nothing in this provision will be construed as relieving the Contractor from performing any other Contract duty not listed herein, nor is the State's right to enforce or to seek other remedies for failure to perform any other Contract duty hereby diminished.

3.19.2 LIQUIDATED DAMAGES FOR VIOLATION OF CONTRACT TERMS REGARDING THE IMPLEMENTATION PERIOD

DHS may impose liquidated damages of $5,000 per requirement specified in the written notice for each day of the delay in completion or submission of Implementation Period requirements beyond the periods defined in the Contract.

If DHS determines that a delay or other non-performance was caused in part by the State, DHS will reduce the liquidated damages proportionately.

3.19.3 LIQUIDATED DAMAGES FOR VIOLATION OF CONTRACT TERMS OR REGULATIONS REGARDING THE OPERATIONS PERIOD

DHS may impose liquidated damages of $1,000 per Contractor requirement not performed or provided during the Operations Period. If after thirty (30) days or such longer period as DHS may allow, the Contractor has not demonstrated the provision or performance of the Contractor requirement specified in the written notice, DHS may issue a written notice that the liquidated damages will be increased to $2,000 per day per Contractor requirement until the Contractor requirement is performed or provided.

If DHS determines that delay of the Contractor requirement was caused in part by the State, DHS will reduce the liquidated damages proportionately.

3.19.4 ANNUAL MEDICAL REVIEWS

DHS may impose liquidated damages of not less than $10,000 and not to exceed $50,000 for each major deficiency determined during the annual medical review. If, after notice, the Contractor does not correct the deficiency to the satisfaction of DHS within thirty (30) days, or longer if authorized by DHS in writing, DHS may impose an additional liquidated damages of $5,000 per day per major deficiency that the major deficiency is not corrected as determined by DHS medical review staff.

If DHS determines that non-performance of the requirement was caused in part by the State, DHS will reduce the liquidated damages proportionately.

3.19.5 CONDITIONS FOR TERMINATION OF LIQUIDATED DAMAGES

Except as waived by the Contracting Officer, no liquidated damages imposed on the Contractor will be terminated or suspended until the Contractor issues a written notice of correction to the Contracting Officer certifying, under penalty of perjury, the correction of condition(s) for which liquidated damages were imposed. Liquidated damages will cease on the day of the Contractor's certification only if subsequent verification of the correction by DHS establishes that the correction has been made in the manner and at the time certified to by the Contractor.

The Contracting Officer will determine whether the necessary level of documentation has been submitted to verify corrections. The Contracting Officer will be the sole judge of the sufficiency and accuracy of any documentation. Corrections must be sustained for a reasonable period of at least ninety (90) days from DHS acceptance; otherwise, liquidated damages may be reimposed without a succeeding grace period within which to correct. The Contractor's use of resources to correct deficiencies will not be allowed to cause other contract compliance problems.

3.19.6 SEVERABILITY OF INDIVIDUAL LIQUIDATED DAMAGES CLAUSES

If any portion of these liquidated damages provisions is determined to be unenforceable, the other portions will remain in full force and effect.

3.20 ASSIGNMENTS

The Contractor will not assign the Contract, in whole or in part, without the prior written approval of DHS.

3.21 DISPUTES AND APPEALS

This Disputes and Appeals section will be used by the Contractor as the means of seeking resolution of disputes on contractual issues.

Filing a dispute will not preclude DHS from recouping the value of the amount in dispute from the Contractor or from offsetting this amount from subsequent capitation payment(s). If the amount to be recouped exceeds 25 percent of the capitation payment, amounts of up to 25 percent will be withheld from successive capitation payments until the amount in dispute is fully recouped. If a recoupment or offset is later found to be inappropriate, DHS will repay the Contractor the full amount of recoupment or offset, plus interest at the Pooled Money Investment Rate pursuant to Government Code Section 16480 et seq.

3.21.1 DISPUTES RESOLUTION BY NEGOTIATION

DHS and Contractor agree to try to resolve all contractual issues by negotiation and mutual agreement at the Contracting Officer level without litigation. The parties recognize that the implementation of this policy depends on open-mindedness, and the need for both sides to present adequate supporting information on matters in question.

Before issuance of a Contracting Officer's decision, informal discussions between the parties by individuals who have not participated substantially in the matter in dispute will be considered by the parties in efforts to reach mutual agreement.

3.21.2 NOTIFICATION OF DISPUTE

Within fifteen (15) days of the date the dispute concerning performance of this Contract arises or otherwise becomes known to the Contractor, the Contractor will notify the Contracting Officer in writing of the dispute, describing the conduct (including actions, inactions, and written or oral communications) which it is disputing.

The Contractor's notification will state, on the basis of the most accurate information then available to the Contractor, the following:

A. That it is a dispute pursuant to this section.

B. The date, nature, and circumstances of the conduct which is subject of the dispute.

C. The names, phone numbers, function, and activity of each Contractor, Subcontractor, DHS/State official or employee involved in or knowledgeable about the conduct.

D. The identification of any documents and the substances of any oral communications involved in the conduct. Copies of all identified documents will be attached.

E. The reason why the Contractor is disputing the conduct.

F. The cost impact to the Contractor directly attributable to the alleged conduct, if any.

G. The Contractor's desired remedy.

The required documentation, including cost impact data, will be carefully prepared and submitted with substantiating documentation by the Contractor. This documentation will serve as the basis for any subsequent appeal.

Following submission of the required notification, with supporting documentation, the Contractor will diligently continue performance of this Contract, including matters identified in the Notification of Disputes, to the maximum extent possible.

3.21.3 CONTRACTING OFFICERS DECISION

Any disputes concerning performance of this Contract will be decided by the Contracting Officer in a written decision stating the factual basis for the decision. The Contracting Officer will serve a copy of the decision on the Contractor. The decision of the Contracting Officer will be rendered within thirty (30) days of receipt of a Notification of Dispute or any additional substantiating documentation requested by the Contracting Officer, unless the Contracting Officer provides a written explanation to the Contractor why a longer period is necessary. The decision will be final and conclusive unless within thirty (30) days from the date of service of that decision the Contractor files with the Contracting Officer a written appeal addressed to the Director, DHS, State of California.

The Contracting Officer's decision will:

A. Find in favor of the Contractor, in which case the Contracting Officer may:

   1. Countermand the earlier conduct which caused the Contractor to file a dispute; or

2. Reaffirm the conduct and, if there is a cost impact sufficient to constitute a change in obligations pursuant to the payment provisions contained in Article V, direct DHS to comply with that section.

B. Deny the Contractor's dispute and, where necessary direct the manner of future performance; or

C. Request additional substantiating documentation in the event the information in the Contractor's notification is inadequate to permit a decision to be made under A. or B. above, and will advise the Contractor as to what additional information is required, and establish how that information will be furnished. The Contractor will have thirty (30) days to respond to the Contracting Officer's request for further information. Upon receipt of this additional requested information, the Contracting Officer will have thirty (30) days to respond with a decision. Failure to supply additional information required by the Contracting Officer within the time period specified above will constitute waiver by the Contractor of all claims in accordance with Section 3.21.5.

3.21.4 CONTRACTOR DUTY TO PERFORM

Pending final determination of any dispute hereunder, the Contractor will proceed diligently with the performance of this Contract and in accordance with the Contracting Officer's decision.

3.21.5 WAIVER OF CLAIMS

If the Contractor fails to submit a Notification of Dispute, supporting and substantiating documentation, or any additionally required information in the manner and within the time specified in the Disputes and Appeals sections, that failure will constitute a waiver by the Contractor of all claims arising out of that conduct, whether direct or consequential in nature.

3.22 ENROLLMENT

The Contractor will accept as Members Medi-Cal beneficiaries in the mandatory and voluntary aid categories as defined in Article II, Section X, Eligible Beneficiaries, including beneficiaries in Aid Codes who elect to enroll with the Contractor or are assigned to the Contractor.

3.22.1 ENROLLMENT - GENERAL

Eligible Beneficiaries residing within the Service Area of the Contractor may be enrolled at any time during the term of this Contract. Eligible Beneficiaries will be accepted by the Contractor up to the limits imposed in Section 3.22.2, Enrollment Totals, and without regard to physical or mental condition, age, sex, race, religion, creed, color, national origin, marital status, sexual orientation or ancestry.

3.22.2 ENROLLMENT TOTALS

* Enrollment under this contract in San Bernardino County will not exceed 136,332.

* Enrollment under this contract in Riverside County will not exceed 83,038.

Total Enrollment under this Contract will not exceed 219,370 Members.

3.22.3 COVERAGE

Member coverage will begin at 12:01 a.m. on the first day of the calendar month for which the Eligible Beneficiary's name is added to the approved list of Members furnished by DHS to the Contractor. The term of membership will continue indefinitely unless this Contract expires, is terminated, or the Member is disenrolled under the conditions described in Section 3.22.5.

3.22.4 ENROLLMENT RESTRICTION

Enrollment may proceed to the plan's maximum total number of Members unless restricted by DHS. Such restrictions will be defined in writing and the Contractor notified at least 10 days prior to the start of the period of restriction. Release of restrictions will be in writing and transmitted to the Contractor at least 10 days prior to the date of the release.

3.22.5 DISENROLLMENT

Disenrollment will take place under the following conditions subject to approval by DHS in accordance with the provisions of Title 22, CCR, Section 53440(b):

A. Disenrollment of a Member is mandatory when:

1. The Member requests Disenrollment

2. The Member's eligibility for Enrollment with the Contractor is

terminated or eligibility for Medi-Cal is ended, including the death of the Member.

3. Enrollment was in violation of Title 22, CCR, Sections 53400 or 53402, or requirements of this Contract regarding Marketing, and DHS or Member requests Disenrollment.

4. Disenrollment is requested in accordance with Welfare and Institutions Code Sections 14303.1 or 14303.2.

5. There is a change of a Member's place of residence to outside the Contractor's Service Area.

B. Disenrollment is based on the circumstances described in Article VI, Section 6.7.2, Excluded Services: Circumstances Under Which Member Disenrolled.

Such Disenrollments will become effective on the first day of the second month following authorization for Disenrollment, provided Disenrollment was requested at least 30 days prior to that date.

C. The Contractor will have the right to recommend to DHS the Disenrollment of any Member in the event of a breakdown in the "doctor-patient relationship" which makes it impossible for the Contractor's providers to render services adequately to a Member.

D. Except as provided in subsection B, Membership will cease at midnight on the last day of the calendar month in which the Member's Disenrollment request is approved by DHS. On the first day of the month following the approval of the Disenrollment request, the Contractor is relieved of all obligations to provide Covered Services to the Member under the terms of this Contract. The Contractor agrees in turn to return to DHS any capitation payment forwarded to the Contractor for persons no longer enrolled under this Contract.

3.23 STANDARDS

Each provider who delivers Covered Services to Members will meet applicable requirements established under Titles XVIII and XIX of the Social Security Act, unless exempted from those provisions; applicable requirements of Chapters 3 and 4, Subdivision 1, Division 3, Title 22, CCR; and the standards expressed in this Contract. All providers of Covered Services must be qualified in accordance with current applicable legal, professional, and technical standards and appropriately

licensed, certified or registered.

3.24 PHARMACEUTICAL SERVICES AND PRESCRIBED DRUGS

The Contractor will provide pharmaceutical services and prescribed drugs, either directly or through Subcontracts, in accordance with all laws and regulations regarding the provision of pharmaceutical services and prescription drugs to Medi-Cal beneficiaries, including, but not limited to, Title 22, CCR, Section 53214. As a minimum, such pharmaceutical services and drugs will be available to Members during Service Site hours. When in the course of treatment provided to a Member by a Contractor provider under emergency circumstances requires the use of drugs, a sufficient quantity of such drugs will be provided to the Member to last until the Member can reasonably be expected to have a prescription filled.

3.25 FACILITIES

Facilities used by the Contractor for providing Covered Services will comply with the provisions of Title 22, CCR, Section 53230.

3.26 LABORATORY CERTIFICATION

A. To ensure that each laboratory used to perform services under this Contract or by Subcontract complies with federal and State law, each location at which any test or examination on materials derived from the human body for the purpose of providing information for the diagnosis, prevention, treatment or assessment of any disease, impairment, or health of a human being is performed shall have in effect:

1. A current, unrevoked or unsuspended certificate, certificate for provider-performed microscopy procedures, certificate of accreditation, certificate of registration or certificate of waiver issued under the requirements of 42 United States Code Section 263a and the regulations adopted thereunder and found at 42 Code of Federal Regulations, Part 493; and, either

a. A current, unrevoked or unsuspended license or registration issued under the requirements of Chapter 3 (commencing with Section 1200) of Division 2 of the California Business and Professions Code and the regulations adopted thereunder; or,

b. Be operated in conformity with Chapter 7 (commencing with Section 1000) of Division 1 of the California Health and Safety

Code and the regulations adopted thereunder.

B. All places used to perform tests or examinations on human biological specimens (materials derived from the human body) are, by definition, "laboratories" under State and federal law.

C. Laboratories may exist, therefore, at Nurses' stations within hospitals, clinics, Skilled Nursing Facilities, operating rooms, surgical centers, rural health clinics, Physician offices, Planned Parenthood clinics, mobile labs, health fairs, and city, county or State labs.

D. Any laboratory that does not comply with the appropriate federal and State law is not eligible for participation in, or reimbursement from, the Medicare, Medicaid, or Medi-Cal programs.

3.27 SUBCONTRACTS

The Contractor may elect to enter into Subcontracts with other entities in order to fulfill the obligations of the Contract. In doing so, the Contractor will meet the subcontracting requirements as stated in Title 22, CCR, Section 53250 and this Contract.

3.27.1 KNOX-KEENE AND REGULATIONS

All Subcontracts will be in writing, and will be entered into in accordance with the requirements of the Knox-Keene Health Care Services Plan Act of 1975, Health and Safety Code Section 1340 et seq.; Title 10, CCR, Section 1300 et seq.; W&I Code Section 14200 et seq.; Title 22, CCR, Section 53000 et seq.; and applicable federal and State laws and regulations.

3.27.2 SUBCONTRACT REQUIREMENTS

Each Subcontract will contain:

A. The subcontractor's agreement to make all of its books and records, pertaining to the goods and services furnished under the terms of the Subcontract, available for inspection, examination or copying:

1. By DHS, DHHS, DOJ, and DOC.

2. At all reasonable times at the subcontractor's place of business or at such other mutually agreeable location in California.

3. In a form maintained in accordance with the general standards applicable to such book or record keeping.

4. For a term of at least five years from the close of DHS' fiscal year in which the Subcontract was in effect.

5. Including all Encounter data for a period of at least five years.

B. Full disclosure of the method and amount of compensation or other consideration to be received by the subcontractor from the Contractor.

C. Subcontractor's agreement to maintain and make available to DHS, upon request, copies of all sub-subcontracts and to ensure that all sub-subcontracts are in writing and require that the Sub-subcontractor:

1. Make all applicable books and records available at all reasonable times for inspection, examination, or copying by DHS, DHHS, DOJ and DOC.

2. Retain such books and records for a term of at least five years from the close of DHS' fiscal year in which the sub-subcontract is in effect.

D. Subcontractor's agreement to assist the Contractor in the transfer of care pursuant to Section 3.16.2, in the event of Contract termination.

E. Subcontractor's agreement to notify DHS in the event the agreement with the Contractor is amended or terminated. Notice is considered given when properly addressed and deposited in the United States Postal Service as first-class registered mail, postage attached.

F. Subcontractor's agreement that assignment or delegation of the Subcontract will be void unless prior written approval is obtained from DHS.

G. Subcontractor's agreement to hold harmless both the State and plan Members in the event the Contractor cannot or will not pay for services performed by the subcontractor pursuant to the Subcontract.

3.27.3 DEPARTMENTAL APPROVAL - NON-FEDERALLY QUALIFIED HMOs

Except as provided in Section 3.27.6, Federally Qualified Health Centers, a provider or management Subcontract entered into by a Contractor which is not a federally qualified HMO will become effective upon approval by DHS in writing, or by operation of law where DHS has acknowledged receipt of the proposed Subcontract, and has failed to approve or disapprove the proposed Subcontract within 60 days of receipt.

Subcontract amendments will be submitted to DHS for prior approval at least 30 days before the effective date of any proposed changes governing compensation, services, or term. Proposed changes which are neither approved or disapproved by DHS, will become effective by operation of law 30 days after DHS has acknowledged receipt or upon the date specified in the Subcontract amendment, whichever is later.

3.27.4 DEPARTMENTAL APPROVAL - FEDERALLY QUALIFIED HMOs

Except as provided in Section 3.27.6, Subcontracts entered into by a plan which is a federally qualified HMO will be:

A. Exempt from prior approval by DHS.

B. Submitted to DHS upon request.

3.27.5 COMPENSATION

Contractor will not enter into any Subcontract if the compensation or other consideration which the subcontractor will receive under the terms of the Subcontract is determined by a percentage of the Contractor's payment from DHS. This subsection will not be construed to prohibit Subcontracts in which compensation or other consideration is determined on a capitation basis.

3.27.6 FEDERALLY QUALIFIED HEALTH CENTERS

Contractor will not enter into a Subcontract with a Federally Qualified Health Center unless DHS approves the provisions regarding rates, which will be subject to the standard that they be reasonable, as determined by DHS, in relation to the services to be provided. In Subcontracts where the Federally Qualified Health Center has made the election to be reimbursed on a reasonable cost basis by the State, provisions will be included that require the subcontractor to keep a record of the number of visits by plan Members separate from Fee-For-Service Medi-Cal beneficiaries, in addition to any other data reporting requirements of the Subcontract.

Subcontracts with FQHCs will also meet Contract requirements of Article VI, Sections 6.6.19 and 6.6.20.

In Subcontracts where a negotiated capitation rate or Fee-For-Service reimbursement rate is agreed to as total payment, a provision that the rate constitutes total payment will be explicitly stated in the Subcontract.

3.27.7 PUBLIC RECORDS

Subcontracts entered into by the Contractor and all information received in accordance with this subsection will be public records on file with DHS, except as specifically exempted in statute. The names of the officers and owners of the subcontractor, stockholders owning more than 10 percent of the stock issued by the subcontractor and major creditors holding more than 5 percent of the debt of the subcontractor will be attached to the Subcontract at the time the Subcontract is presented to DHS.

3.27.8 DISCLOSURES

Each Subcontract will contain at least the elements required by Section 3.27.2, Subcontract Requirements, and the following:

A. Full disclosure of the method and amount of compensation or other consideration to be received by the subcontractor from the plan.

B. Specification of the services to be provided.

C. Specification that the Subcontract will be governed by and construed in accordance with all laws, regulations, and contractual obligations of the Contractor.

D. Specification that the Subcontract or Subcontract amendments will become effective only as set forth in Sections 3.27.3 or 3.27.4.

E. Specification of the term of the Subcontract including the beginning and ending dates as well as methods of extension, renegotiation and termination.

F. Subcontractor's agreement to submit reports as required by the Contractor.

3.27.9 PAYMENT

Contractor will timely pay provider claims within thirty (30) working days after receipt, unless the Contractor is a federally qualified health maintenance organization, in which case the requirement is forty-five (45) working days from receipt. Notice must be provided to providers in the case of contested claims within thirty (30) working days after receipt, unless the Contractor is a federally qualified health maintenance organization, in which case the requirement is forty-five (45) working days from receipt. Contractor will have sufficient claims processing/payment systems to timely process and pay provider claims and to reasonably determine the status of received claims and calculate provisions for Incurred But Not Reported Claims.

3.28 CONFIDENTIALITY OF DATA

The Contractor will perform the following duties and responsibilities with respect to confidentiality of information and data.

3.28.1 CONFIDENTIALITY OF INFORMATION

Notwithstanding any other provision of this Contract, names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with Title 42, CFR, Section 431.300 et seq., Section 14100.2, W&I Code, and regulations adopted thereunder. For the purpose of this Contract, all information, records, data, and data elements collected and maintained for the operation of the Contract and pertaining to Members will be protected by the Contractor from unauthorized disclosure.

The Contractor may release Medical Records in accordance with applicable law pertaining to the release of this type of information.

3.28.2 CONTRACTOR'S DUTIES TO MAINTAIN CONFIDENTIALITY

With respect to any identifiable information concerning a Member under this Contract that is obtained by the Contractor or its subcontractors, the Contractor: (1) will not use any such information for any purpose other than carrying out the express terms of this Contract, (2) will promptly transmit to DHS all requests for disclosure of such information, except requests for Medical Records in accordance with applicable law, (3) will not disclose except as otherwise specifically permitted by this Contract, any such information to any party other than DHS without DHS' prior written authorization specifying that the information is releasable under Title 42, CFR, Section 431.300 et seq., Section 14100.2, W&I Code, and regulations adopted thereunder, and (4) will, at the expiration or termination of this Contract, return all

such information to DHS or maintain such information according to written procedures sent to the Contractor by DHS for this purpose.

3.29 KEY PERSONNEL (DISCLOSURE FORM)

A. Contractor will file an annual statement with DHS disclosing any purchases or leases of services, equipment, supplies, or real property from an entity in which any of the following persons have a substantial financial interest:

1. Any person also having a substantial financial interest in the Contractor.

2. Any director, officer, partner, trustee, or employee of the Contractor.

3. Any member of the immediate family of any person designated in 1 or 2 above.

B. Comply with federal regulations 42 CFR 455.104 (Disclosure by providers and fiscal agents: Information on ownership and control), 42 CFR 455.105 (Disclosure by providers: Information related to business transactions), and 42 CFR 455.106.

3.30 CONFLICT OF INTEREST - CURRENT AND FORMER STATE EMPLOYEES

Contractor will not utilize in the performance of this Contract any State officer or employee in the State civil service or other appointed State official unless the employment, activity, or enterprise is required as a condition of the officer's or employee's regular state employment. Employee in the State civil service is defined to be any person legally holding a permanent or intermittent position in the State civil service.

3.31 RECORD KEEPING, AUDIT/INSPECTION OF RECORDS

The Contractor will maintain such books and records necessary to disclose how the Contractor discharged its obligations under this Contract. These books and records will disclose the quantity of Covered Services provided under this contract, the quality of those services, the manner and amount of payment made for those services, the persons eligible to receive Covered Services, the manner in which the Contractor administered its daily business, and the cost thereof.

3.31.1 BOOKS AND RECORDS

These books and records will include, but are not limited to, all physical records originated or prepared pursuant to the performance under this Contract including working papers; reports submitted to DHS; financial records; all Medical Records, medical charts and prescription files; and other documentation pertaining to medical and non-medical services rendered to Members.

3.31.2 RECORDS RETENTION

These books and records will be maintained for a minimum of five years from the end of the Fiscal Year in which the Contract expires or is terminated, or, in the event the Contractor has been duly notified that DHS, DHHS, DOJ, or the Comptroller General of the United States, or their duly authorized representatives, have commenced an audit or investigation of the Contract, until such time as the matter under audit or investigation has been resolved, whichever is later.

3.32 AMENDMENT OF CONTRACT

Should either party during the life of this Contract desire a change in this Contract, that change will be proposed in writing to the other party. The other party will acknowledge receipt of the proposal within 10 days of receipt of the proposal. The party proposing any such change will have the right to withdraw the proposal any time prior to acceptance or rejection by the other party. Any proposal will set forth a detailed explanation of the reason and basis for the proposed change, a complete statement of cost and benefits of the proposed change and the text of the desired amendment to this Contract which would provide for the change. If the proposal is accepted, this Contract will be amended to provide for the change mutually agreed to by the parties on the condition that the amendment is approved by DHHS, and the State Department of Finance, if necessary.

3.33 CONTRACTOR CERTIFICATIONS

With respect to any report, invoice, record, papers, documents, books of account, or other Contract required data submitted, pursuant to the requirements of this Contract, the Contractor's Representative or his/her designee will certify, under penalty of perjury, that the report, invoice, record, papers, documents, books of account or other Contract required data is current, accurate, complete and in full compliance with legal and contractual requirements to the best of that individual's knowledge and belief, unless the requirement for such certification is expressly waived by DHS in writing.

3.34 CHANGE REQUIREMENTS

3.34.1 GENERAL PROVISIONS

The parties recognize that during the life of this Contract, the Medi-Cal Managed Care program will be a dynamic program requiring numerous changes to its operations and that the scope and complexity of changes will vary widely over the life of the Contract. The parties agree that the development of a system which has the capability to implement such changes in an orderly and timely manner is of considerable importance.

3.34.2 CONTRACTOR'S OBLIGATION TO IMPLEMENT

The Contractor will make changes mandated by DHS. In the case of mandated changes in policy, regulations, statutes, or judicial interpretation, DHS may direct the Contractor to immediately begin implementation of any change by issuing a Change Order. If DHS issues a Change Order, the Contractor will be obligated to implement the required changes while discussions relevant to any capitation rate adjustment, if applicable, are taking place.

DHS may, at any time, within the general scope of the Contract, by written notice, issue Change Orders to the Contract. This process will make use of the following documents:

Medi-Cal Managed Care Division (MMCD) Policy Letters - This document will be utilized to notify the Contractor of clarifications made to the Medi-Cal Managed Care Program. This document will include instructions to the Contractor regarding implementation. This document will also be used to initiate various ongoing changes required of the Contractor throughout the Contract, the performance of which falls within the Contract's agreed upon capitated rate.

Change Orders will be used when an Annual Capitation Rate, if applicable, is adjusted (See Article V, Payment Provisions). Change Orders may also be used to amend the Contractor's responsibilities.

3.35 MINORITY/WOMEN/DISABLED VETERAN BUSINESS ENTERPRISES (M/W/DVBE)

Contractor will comply with applicable requirements of California law relating to Minority/Women/Disabled Veteran Business Enterprises (M/W/DVBE) commencing at Section 10115 of the Public Contract Code.

3.36 DRUG FREE WORKPLACE ACT OF 1990

Contractor will comply with applicable requirements of the Drug Free Workplace Act of 1990 (Government Code Section 8355).

3.37 INDEMNIFICATION

3.37.1 INDEMNIFICATION BY CONTRACTOR

Contractor agrees to indemnify, defend, and save harmless the State, its officers, agents, and employees:

A. From any and all claims and losses accruing or resulting to any and all Contractors, Subcontractors, materialmen, laborers, and any other person, firm, corporation, or other entity furnishing or supplying work services, materials, or supplies in connection with the performance of this Contract;

B. From any and all claims and losses accruing or resulting to any person, firm, corporation, or other entity injured or damaged by the Contractor, its officers, employees, or Subcontractors in the performance of this Contract.

3.38 AMERICANS WITH DISABILITIES ACT OF 1990 REQUIREMENTS

The Contractor will comply with all applicable federal requirements in Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990 (42 USC, Section 12100 et seq.), Title 45, Code of Federal Regulations (CFR), Part 84 and Title 28, CFR, Part 36.

3.39 NEWBORN CHILD COVERAGE

The Contractor will provide Covered Services to a child born to a Member for the month of birth and the following month. For a child born in the month immediately preceding the mother's membership, the Contractor will provide Covered Services to the child during the mother's first month of Enrollment. No additional capitation payment will be made to the Contractor by DHS.

3.40 RECOVERY FROM OTHER SOURCES OR PROVIDERS

Contractor will make reasonable efforts to recover the value of Covered Services rendered to Members whenever the Members are covered for the same services, either fully or partially, under any other State or federal medical care program or under other contractual or legal entitlement including, but not limited to, a private

group or indemnification program, but excluding instances of the tort liability of a third party. Contractor will coordinate benefits with other programs or entitlement, recognizing the other coverage as primary and Medi-Cal as the payor of last resort. Such monies recovered are retained by the Contractor.

3.41 THIRD-PARTY TORT LIABILITY

Contractor will make no claim for recovery of the value of Covered Services rendered to a Member when such recovery would result from an action involving the tort liability of a third party or casualty liability insurance including Workers' Compensation awards and uninsured motorists coverage. The Contractor will identify and notify DHS of cases in which an action by the Medi-Cal Member involving the tort or Workers' Compensation liability of a third party could result in recovery by the Member of funds to which DHS has lien rights under Article 3.5 (commencing with Section 14124.70), Part 3, Division 9, Welfare and Institutions Code. Such cases will be referred to DHS within 10 days of discovery. To assist DHS in exercising its responsibility for such recoveries, Contractor will meet the following requirements:

A. If DHS requests payment information and/or copies of paid invoices/claims for Covered Services to an individual Member, Contractor will deliver the requested information within 10-30 days of the request. The value of the Covered Services will be calculated as the usual, customary and reasonable charge made to the general public for similar services or the amount paid to subcontracted providers or out of plan providers for similar services.

B. Information to be delivered will contain the following data items:

1. Member name.

2. Full 14 digit Medi-Cal number.

3. Social Security Number.

4. Date of birth.

5. Contractor name.

6. Provider name (if different from Contractor).

7. Dates of service.

8. Diagnosis code and/or description of illness/injury.

9. Procedure code and/or description of services rendered.

10. Amount billed by a subcontractor or out of plan provider to Contractor (if applicable).

11. Amount paid by other health insurance to Contractor or subcontractor.

12. Amount and date paid by Contractor to subcontractor or out of plan provider (if applicable).

13. Date of denial and reasons (if applicable).

C. Contractor will identify to DHS the name, address and telephone number of the person responsible for receiving and complying with requests for mandatory and/or optional at-risk service information.

D. If Contractor receives any requests by subpoena from attorneys, insurers, or beneficiaries for copies of bills, Contractor will provide DHS with a copy of any document released as a result of such request, and will provide the name and address and telephone number of the requesting party.

3.42 OBTAINING DHS APPROVAL

Contractor will obtain written approval from DHS prior to implementing or using the following:

A. Providers of Covered Services, except for providers of seldom used or unusual services as determined by DHS.

B. Facilities.

C. Subcontracts and sub-subcontracts with providers or for management services if the Contractor is not a federally qualified HMO.

D. Marketing activities.

E. Marketing materials, promotional materials, and public information releases relating to performance under this Contract, Member service guides; Member newsletters; and provider claim forms unique to the Contract.

F. Member Grievance procedure.

G. Member Disenrollment procedure.

H. Enrollment, Disenrollment and Grievance forms.

Revisions to these items must be approved by DHS prior to taking effect.

3.43 PILOT PROJECTS

DHS, pursuant to W&I Code Section 14094.3(c)(2), may establish pilot projects to test alternative managed care models tailored to the special health care needs of children under the California Children Services (CCS) Program. These pilot projects may affect the Contractor's obligations under the Contract in the areas of Covered Services, eligible enrollees, and administrative systems. These pilot projects will be implemented through Contract amendment pursuant to Section 3.32 and, if necessary, Change Order pursuant to Section 3.34. DHS will not require the Contractor to cover CCS services under the capitation rate as part of a pilot project unless the Contractor is a voluntary participant in the project.

ARTICLE IV - DUTIES OF THE STATE

In discharging its obligations under this Contract, the State will perform the following duties:

4.1 PAYMENT FOR SERVICES

Pay the appropriate capitation payments set forth in Article V, Payment Provisions, to the Contractor for each eligible Member under this Contract, and ensure that such payments are reasonable and do not exceed the amount set forth in 42 CFR, Section 447.361. Payments will be made monthly for the duration of this Contract.

4.2 MEDICAL REVIEWS

Conduct medical reviews at least once every 12 months in accordance with the provisions of Section 14456, Welfare and Institutions Code, and issue medical review reports to the Contractor detailing findings, recommendations, Corrective Action and liquidated damages, as appropriate.

4.3 FACILITY INSPECTIONS

Conduct random on-site inspections, at the discretion of DHS of health Facilities and review and approve, in writing, the required Site Inspection Forms prior to their use for providing services to Members under the terms of this Contract. Inspections for continuing Facility adequacy will be conducted periodically thereafter.

4.4 ENROLLMENT PROCESSING

Review applications for Enrollment submitted timely by the Enrollment Contractor, and check the eligibility of applicants for services under this Contract. For those applications for Enrollment received prior to the specified deadlines, DHS will provide to the Contractor a list of Members on a monthly basis, effective the first of the following month.

Those applications for Enrollment received after the specified submission deadlines will become effective the first day of the second month following the receipt of the late application.

4.5 DISENROLLMENT PROCESSING

Review and process requests for Disenrollment and notify the Contractor and the Member of its decision.

4.6 TESTING AND CERTIFICATION OF MARKETING REPRESENTATIVES

Test all Contractor Marketing Representatives for knowledge of the program prior to their engaging in Marketing or Medi-Cal Managed Care information activities on behalf of the Contractor. Certify as qualified Marketing Representatives, those persons demonstrating adequate knowledge of the program, provided they are of good moral character.

4.7 APPROVAL PROCESS

Acknowledge in writing, within five working days of receipt, the receipt of any material sent to DHS by the Contractor under the provisions of Article III, Section 3.42, Obtaining Departmental Approval. Within 60 days of receipt, approve in writing the use of such material or provide the Contractor with a written explanation why its use is not approved.

4.8 PROGRAM INFORMATION

Provide the Contractor with complete and current information with respect to pertinent policies, procedures, and guidelines affecting the operation of this Contract.

4.9 SANCTIONS

Apply sanctions, in accordance with Title 22, CCR, Section 53350, to the Contractor for violations of the terms of this Contract, applicable federal and State laws and regulations.

4.10 CATASTROPHIC COVERAGE LIMITATION

Limit the Contractor's liability to provide or arrange and pay for care for illness of, or injury to, Members which results from or is greatly aggravated by, a catastrophic occurrence or disaster.

4.11 RISK LIMITATION

Agree, that there will be no risk limitation and that Contractor will have full financial liability to provide covered services to enrolled beneficiaries.

4.12 NOTICE OF TERMINATION OF CONTRACT

Notify Members of their health care benefits and options available upon termination or expiration of this Contract.

4.13 ACCESS REQUIREMENTS AND STATE'S RIGHT TO MONITOR

The State will have the right to monitor all aspects of the Contractor's operation for compliance with the provisions of this Contract and applicable federal and State laws and regulations. Such monitoring activities will include, but are not limited to, inspection and auditing of Contractor, subcontractor, and provider Facilities, management systems and procedures, and books and records as the Director deems appropriate, at any time during the Contractor's or other Facility's normal business hours. The monitoring activities will be either announced or unannounced.

To assure compliance with the Contract and for any other reasonable purpose, the State and its authorized representatives and designees will have the right to premises access, with or without notice to the Contractor. This will include the MIS operations site or such other place where duties under the Contract are being performed.

Staff designated by the State or DHS will have access to all security areas and the Contractor will provide, and will require any and all of its subcontractors to provide, reasonable facilities, cooperation and assistance to State representative(s) in the performance of their duties. Access will be undertaken in such a manner as to not unduly delay the work of the Contractor and/or the subcontractor(s).

ARTICLE V - PAYMENT PROVISIONS

5.0 PAYMENT PROVISIONS

5.1 CONTRACTOR RISK IN PROVIDING SERVICES

Contractor will assume the total risk of providing the Covered Services on the basis of the periodic capitation payment for each Member, except as otherwise allowed in this Contract. Any monies not expended by the Contractor after having fulfilled obligations under this Contract will be retained by the Contractor.

5.2 AMOUNTS PAYABLE

The maximum amount payable for the 1995-96 Fiscal Year ending June 30, 1996 will not exceed $32,080,630. Any requirement of performance by DHS and the Contractor for the period of the Contract subsequent to June 30, 1996 will be dependent upon the availability of future appropriations by the Legislature for the purpose of this Contract. If funds become available for purposes of this Contract from future appropriations by the Legislature, the maximum amount payable under this Contract in the 1996-97 Fiscal Year ending June 30, 1997 will not exceed $194,472,680. If funds become available for purposes of this Contract from future appropriations by the Legislature, the maximum amount payable under this Contract in the 1997-98 Fiscal Year ending June 30, 1998 will not exceed $194,472,680. If funds become available for purposes of this Contract from future appropriations by the Legislature, the maximum amount payable under this Contract in the 1998-99 Fiscal Year ending June 30, 1999 will not exceed $194,472,680. If funds become available for purposes of this Contract from future appropriations by the Legislature, the maximum amount payable under this Contract in the 1999-2000 Fiscal Year ending June 30, 2000 will not exceed $194,472,680. If funds become available for purposes of this Contract from future appropriations by the Legislature, the maximum amount payable under this Contract in the 2000-01 Fiscal Year ending June 30, 2001 will not exceed $194,472,680. If funds become available for purposes of this Contract from future appropriations by the Legislature, the maximum amount payable under this Contract in the 2001-02 Fiscal Year ending June 30, 2002 will not exceed $145,854,520. The maximum amount payable under this Contract will not exceed $1,150,298,550.

5.3 CAPITATION RATES

DHS will remit to the Contractor a capitation payment each month for each Medi-Cal Member that appears on the approved list of Members supplied to the Contractor by DHS. The capitation rate shall be the amount specified in this Article. The payment period for health care services will commence on the first day of operations, as determined by DHS. Capitation payments will be made in accordance with the following schedule of capitation payment rates:

AID CODE CATEGORIES

Family: 01,02,08,30,32,33,34,35,38,39,3A,3C,3P,3R,40,42,4C,4K,54,59,5K;
Aged : 10,14,16,18; Disabled: 20,24,26,28,36,60,64,66,68,6A,6C;
Child : 03,04,45,82; Adult : 86

SAN BERNARDINO COUNTY 7/95 - 5/96		SAN BERNARDINO COUNTY 6/96 - 9/97	
Family	$ 70.01	Family	$ 71.59
Child	$ 67.91	Child	$ 67.17
Aged	$ 117.66	Aged	$ 121.76
Disabled	$ 177.15	Disabled	$ 174.45
Adult	$ 536.02	Adult	$ 554.73

RIVERSIDE COUNTY 7/95 - 5/96		RIVERSIDE COUNTY 6/96 - 9/97	
Family	$ 74.70	Family	$ 76.39
Child	$ 68.51	Child	$ 67.74
Aged	$ 110.37	Aged	$ 114.62
Disabled	$ 181.61	Disabled	$ 178.77
Adult	$ 492.78	Adult	$ 509.94

5.4 CAPITATION RATES CONSTITUTE PAYMENT IN FULL

Capitation rates for each rate period, as calculated by DHS, are prospective rates and constitute payment in full, subject to any stop loss reinsurance provisions, on behalf of a Member for all Covered Services required by such Member and for all Administrative Costs incurred by the Contractor in providing or arranging for such services, but do not include payment for the recoupment of current or previous losses incurred by the Contractor. DHS is not responsible for making payments for recoupment of losses. The basis for the determination of the capitation payment rates is outlined in Attachment I (consisting of 20 pages).

5.5 DETERMINATION OF RATES

DHS will determine the capitation rates for the initial period December 1, 1995, or the Contract effective date of operations if later, through September 30, 1997. Subsequent to September 30, 1997 and through the duration of the Contract, DHS will make an annual redetermination of rates for each rate year defined as the 12 month period from October 1, through September 30. DHS reserves the right to redetermine rates on an actuarial basis or move to a negotiated rate for each rate year. All payments beyond June 1996 and rate adjustments beyond September 1997 are subject to future appropriations of funds by the Legislature and the Department of Finance approval. Further, all payments are subject to the availability of Federal congressional appropriation of funds.

If DHS redetermines rates on an actuarial basis, DHS will determine whether the rates will be increased, decreased, or remain the same. If it is determined by DHS that the Contractor's capitation rates will be increased or decreased, that increase or decrease will be effectuated through a Change Order to this Contract in accordance with the provisions of Article III, Section 3.34, Change Requirements, subject to the following provisions:

A. The Change Order will be effective as of October 1 of each year covered by this Contract.

B. In the event there is a any delay in a determination to increase or decrease capitation rates, so that a Change Order may not be processed in time to permit payment of new rates commencing October 1, the payment to the Contractor will continue at the rates then in effect. Those continued payments will constitute interim payment only. Upon final approval of the Change Order providing for the rate change, DHS will make adjustments for those months for which interim payment was made.

C. Notwithstanding paragraph B, payment of the new annual rates will commence no later than December 1, provided that a Change Order providing for the new annual rates has been issued by DHS. By accepting payment of new annual rates prior to full approval by all control agencies of the Change Order to this Contract implementing such new rates, the Contractor stipulates to a confession of judgment for any amounts received in excess of the final approved rate. If the final approved rate differs from the rates agreed upon by the Contractor and DHS:

   1. Any underpayment by the State will be paid to the Contractor within 30 days after final approval of the new rates.

2. Any overpayment to the Contractor will be recaptured by the State's withholding the amount due from the Contractor's next capitation check.

   If the amount to be withheld from that capitation check exceeds 25 percent of the capitation payment for that month, amounts up to 25 percent will be withheld from successive capitation payments until the overpayment is fully recovered by the State.

5.6 REDETERMINATION OF RATES - OBLIGATION CHANGES

The Capitation rates may be adjusted during the rate year to provide for a change in obligations which results in an increase or decrease of more than one percent of cost (as defined in Title 22, CCR, Section 53322) to the Contractor. Any adjustments will be effectuated through a Change Order to the Contract subject to the following provisions:

A. The Change Order will be effective as of the first day of the month in which the change in obligations is effective, as determined by DHS.

B. In the event DHS is unable to process the Change Order in time to permit payment of the adjusted rates as of the month in which the change in obligations is effective, payment to Contractor will continue at the rates then in effect. Continued payment will constitute interim payment only. Upon final approval of the Change Order providing for the change in obligations, DHS will make adjustments for those months for which interim payment was made.

If mutual agreement between DHS and the Contractor cannot be attained on capitation rates for rate years subsequent to September 30, 1997, the Contractor will retain the right to terminate the Contract, but no earlier than September 30, 1998. Notification of intent to terminate a Contract will be in writing and provided to DHS at least nine months prior to the effective date of termination. Contract termination due to an inability to reach agreement upon capitation rates is limited to termination at the end of each rate year, September 30th. Therefore, Contractor must provide termination notification by December 31st of the prior year for an effective termination date of September 30th. DHS will pay the capitation rates last offered for that rate period until the Contract is terminated.

5.7 REINSURANCE

A. The Contractor may obtain reinsurance (stop loss coverage) for the cost of providing Covered Services under this Contract. Reinsurance will not limit

the Contractor's liability below $5,000 per Member for any 12-month period as specified by DHS. The Contractor may obtain reinsurance for the total cost of services provided to Members by non-contractor emergency service providers and for 90 percent of all costs exceeding 115 percent of its income during any Contractor fiscal year.

B. If Contractor selects State reinsurance, Contractor will submit a reinsurance claim form along with copies of the actual claims upon exceeding the reinsurance threshold. As part of the processing, actual claims are priced to appropriate Medi-Cal rates and the appropriate amount in excess of the reinsurance threshold is remitted to the Contractor by DHS.

C. Claims submitted will not be paid by DHS unless received by DHS not later than the last day of the sixth month following the end of the twelve-month period in which they were incurred.

D. The time specified for submission of claims may be extended for a period not to exceed one year upon a finding of "good cause" by the Director in the following circumstances:

1. Where the claim involves health coverage, other than Medi-Cal, and the delay is necessary to permit the Contractor to obtain payment, partial payment, or proof of non-liability of that other health coverage.

2. Where the claim submission was delayed due to eligibility certification or determination by the State or county.

3. Where there was substantial interference with claim submission due to damage to or destruction of the Contractor's (or subcontractor's) business office or records by a natural disaster, including fire, flood or earthquake or other similar circumstances.

4. Where delay in claims submission was due to other circumstances that are clearly beyond the control of the Contractor. Circumstances that will not be considered beyond the control of the Contractor include, but are not limited to:

a. Negligence or delay of the Contractor or Contractor's employees, agents, and subcontractors.

b. Misunderstanding of or unfamiliarity with Medi-Cal regulations, or the terms of this Contract.

c. Illness, absence or other incapacity of a Contractor's employee, agent, or subcontractor responsible for preparation and submission of claims.

d. Delays caused by the United States Postal Service or any private delivery service.

5.8 CATASTROPHIC COVERAGE LIMITATION

DHS may limit the Contractor's liability to provide or arrange and pay for care for illness of, or injury to, Members which results from or is greatly aggravated by, a catastrophic occurrence or disaster.

Contractor will return a prorated amount of the capitation payment following the Director's invocation of the catastrophic coverage limitation. The amount returned will be determined by dividing the total capitation payment by the number of days in the month. The amount will be returned to DHS for each day in the month after the Director has invoked the catastrophic coverage limitation clause.

5.9 FINANCIAL SECURITY

If capitation is prepaid, Contractor will provide satisfactory evidence of and maintain Financial Security in an amount equal to at least one month's capitation payment, in a manner specified by DHS. The Financial Security will remain in effect for at least 90 days following termination or expiration of this Contract or until, in the judgment of DHS the obligations set forth in this Contract are fulfilled.

5.10 LIMITATION TO FEDERAL FINANCIAL PARTICIPATION

Limitation to Federal Financial Participation is as follows:

A. It is mutually understood between the parties that this Contract may have been written before ascertaining the availability of congressional appropriation of funds, for the mutual benefit of both parties in order to avoid program and fiscal delays which would occur if the Contract were executed after that determination was made.

B. This Contract is valid and enforceable only if sufficient funds are made available to the State by the United States government for each Fiscal Year for the purpose of this program. In addition, this Contract is subject to any additional restrictions, limitations or conditions enacted by the Congress or any statute enacted by the Congress which may affect the provisions, terms or

funding of this Contract in any manner.

C. It is mutually agreed that if Congress does not appropriate sufficient funds for the program, this Contract will be amended to reflect any reduction in funds.

D. DHS has the option to terminate the Contract under the 60 day termination clause or to amend the Contract to reflect any reduction in funds.

5.11 RECOVERY OF CAPITATION PAYMENTS

DHS will have the right to recover amounts paid to the Contractor in the following circumstances as specified:

A. DHS determines that a Member has either been improperly enrolled, or should have been disenrolled with an effective date in a prior month. DHS may recover the capitation payments made to the Contractor for the Member and absolve the Contractor from all financial and other risk for the provision of services to the Member under the terms of the Contract for the month or months in question.

B. As a result of the Contractor's failure to perform contractual responsibilities to comply with mandatory federal Medicaid requirements, the Department of Health and Human Services (DHHS) disallows Federal Financial Participation (FFP) for payments made by DHS to the Contractor. DHS may recover the amounts disallowed by DHHS by an offset to the capitation payment made to the Contractor. If recovery of the full amount at one time imposes a financial hardship on the Contractor, DHS at its discretion may grant a Contractor's request to repay the recoverable amounts in monthly installments over a period of consecutive months not to exceed six (6) months.

C. If DHS determines that any other erroneous or improper payment not mentioned above has been made to the Contractor, DHS may recover the amounts determined by an offset to the capitation payment made to the Contractor. If recovery of the full amount at one time imposes a financial hardship on the Contractor, DHS, at its discretion, may grant a Contractor's request to repay the recoverable amounts in monthly installments over a period of consecutive months not to exceed six (6) months.

ARTICLE VI - SCOPE OF WORK

6.0 ORGANIZATION

6.1 LEGAL CAPACITY

Contractor will maintain the legal capacity to contract with DHS and maintain appropriate licensure as a health care service plan in accordance with the Knox-Keene Act.

6.2 ADMINISTRATION/STAFFING

6.2.1 CONTRACT PERFORMANCE

Contractor will maintain the organization and staffing, for implementing and operating the Contract. Contractor will ensure the following:

A. The organization has an accountable governing body.

B. This Contract is a high priority and that the Contractor is committed to supplying any necessary resources to assure full performance of the Contract.

C. If the Contractor is a subsidiary organization, the attestation of the parent organization that this Contract will be a high priority to the parent organization, and that the parent organization is committed to supplying any necessary resources to assure full performance of the Contract.

6.2.2 MEDICAL DIRECTOR

Contractor will maintain a full time Physician as Medical Director who will assume the following responsibilities:

A. Ensure that medical decisions are rendered by qualified medical personnel, unhindered by fiscal or administrative management.

B. Ensure that medical care provided meets the standards for acceptable medical care.

C. Ensure that medical protocols and rules of conduct for plan medical personnel are followed.

D. Develop and implement medical policy.

E. Resolve medically related Grievances.

F. Have a significant role in monitoring, investigating and hearing Grievances.

G. Have a significant role in the Contractor's Quality Improvement program.

6.2.3 MEDICAL DECISIONS

Contractor will ensure that medical decisions are not unduly influenced by fiscal management.

6.2.4 MEDICAL DIRECTOR CHANGES

The Contractor will report to DHS any changes in the status of the Medical Director within ten (10) days.

6.2.5 ADMINISTRATIVE DUTIES/RESPONSIBILITIES

The Contractor will maintain the organizational and administrative capabilities to carry out its duties and responsibilities under the Contract. This will include as a minimum the following:

A. Designated persons, qualified by training or experience, to be responsible for the Medical Record service.

B. Member and Enrollment reporting systems as specified in Section 6.4, Management and Information Systems and Section 6.9, Member Services/ Grievance Systems.

C. A Member Grievance procedure, as specified in Section 6.9, Member Services/Grievance System.

D. Data reporting capabilities sufficient to provide necessary and timely reports to DHS, as required by Section 6.4, Management Information Systems.

E. Financial records and books of account maintained on the accrual basis, in accordance with Generally Accepted Accounting Principles, which fully disclose the disposition of all Medi-Cal program funds received, as specified in Section 6.3, Financial Information.

6.2.6 MEMBER REPRESENTATION

Contractor will ensure that Medi-Cal Members are represented and participate in establishing the public policy of the plan, regarding the plan's Medi-Cal programs.

6.3 FINANCIAL INFORMATION

6.3.1 FINANCIAL VIABILITY/STANDARDS COMPLIANCE

The Contractor will demonstrate financial viability/standards compliance to DHS' satisfaction for each of the following elements:

A. Tangible Net Equity (TNE).

The Contractor at all times will be in compliance with the TNE requirements in accordance with Title 10, CCR, Section 1300.76.

B. Administrative Costs.

Contractor's Administrative Costs will not exceed the guidelines as established under Title 10, CCR, Section 1300.78.

C. Standards of Organization and Financial Soundness.

The Contractor will maintain reasonable standards of its organization sufficient to conduct the proposed operations and that its financial resources are sufficient for sound business operations in accordance with Title 10, CCR, Sections 1300.67.3, 1300.75.1, 1300.76, 1300.76.3, 1300.77.1, 1300.77.2, 1300.77.3, 1300.77.4, 1300.78, and Title 22, CCR, Sections 53200, 53251, and 53324.

D. Working Capital.

The Contractor will maintain a working capital ratio of at least 1:1.

6.3.2 FINANCIAL AUDIT/REPORTS

The Contractor will ensure that an annual audit is performed according to Section 14459, W&I Code. Combined Financial Statements will be prepared to show the financial position of the overall related health care delivery system when delivery of care or other services is dependent upon Affiliates. Financial Statements will be presented in a form that clearly shows the financial position of the Contractor

separately from the combined totals. Inter-entity transactions and profits will eliminated if combined statements are prepared. The Contractor will have separate certified Financial Statements prepared if an independent accountant decides that preparation of combined statements is inappropriate.

A. The independent accountant will state in writing reasons for not preparing combined Financial Statements.

B. The Contractor will provide supplemental schedules that clearly reflect all inter-entity transactions and eliminations necessary to enable DHS to analyze the overall financial status of the entire health care delivery system.

1. In addition to annual certified Financial Statements the Contractor will complete the entire 1989 HMO Financial Report of Affairs and Conditions Format, commonly known as the "Orange Blank". The Certified Public Accountant's (CPA) audited Financial Statements and the "Orange blank" report will be submitted to DHS no later than ninety (90) calendar days after the close of the Contractor's Fiscal Year.

2. On a quarterly basis the Contractor will submit to DHS forty-five (45) calendar days after the end of each quarter under this Contract financial reports required by Title 22, CCR, Section 53324(c). The required quarterly financial reports will be prepared on the "Orange Blank" format and will include, at a minimum, the following reports/schedules:

a. Jurat.

b. Report 1A and 1B: Balance Sheet.

c. Report 2: Statement of Revenue, Expenses, and Net Worth.

d. Statement of Cash Flow, prepared in accordance with Financial Accounting Standards Board Statement Number 96 (This statement is prepared in lieu of Report #3: Statement of Changes in Financial Position for Generally Accepted Accounting Principles (GAAP) compliance.

e. Report 4: Enrollment and Utilization Table.

f. Schedule F: Unpaid Claims Analysis.

g. Appropriate footnote disclosures in accordance with GAAP.

C. The Contractor will authorize the independent accountant to allow representatives of DHS, upon written request, to inspect any and all working papers related to the preparation of the audit report.

6.3.3 MONTHLY FINANCIAL STATEMENTS

The Contractor may be required to file monthly Financial Statements at DHS' request. If the Contractor is required to file monthly Financial Statements with DOC, they will file monthly Financial Statements with DHS.

6.3.4 COMPLIANCE WITH AUDIT REQUIREMENTS

The Contractor will cooperate with DHS' own independent audits annually or as necessary for good cause, at the discretion of DHS. Such audits may be waived upon submission of the financial audit for the same period conducted by DOC pursuant to Section 1382 of the Health and Safety Code.

6.3.5 SUBMITTAL OF FINANCIAL INFORMATION

The Contractor will prepare financial information requested in accordance with Generally Accepted Accounting Principles (GAAP) and where Financial Statements/projections are requested these statements/projections should be prepared on the 1989 HMO Reporting Format (commonly known as the "Orange Blank"). Where appropriate, reference has been made to the Knox-Keene Health Care Service Plan Act of 1975 Rules, found under Title 10, CCR, Section 1300.51 et. seq. Information submitted will be based on current operations.

6.4 MANAGEMENT INFORMATION SYSTEM

6.4.1 MANAGEMENT INFORMATION SYSTEM (MIS) CAPABILITY

The Contractor will maintain an MIS that will provide support for all functions of the plan's processes and procedures related to the flow and use of data within the plan. The MIS must enable the Contractor to meet the contractual requirements contained in this Article. It will have the capability to capture and utilize various data elements to develop information for plan administration.

6.4.2 ENCOUNTER DATA SUBMITTAL

The Contractor will submit Encounter data to DHS on a monthly basis 90 days following the end of the reporting month in which the Encounter occurred as specified in the Managed Care Encounter Data Reporting Manual. Encounter data will include the data elements as outlined in Attachment 9.4-B, Managed Care Encounter Data Reporting Elements of the RFA.

6.4.3 ACCESS TO MIS

The Contractor will provide on-line read-only access to DHS to the Contractor's MIS.

6.4.4 LATE REPORTS

The Contractor will ensure that, upon written notice by DHS of a late report, that they will submit the report within five (5) working days from the date of the post mark, or longer if allowed by DHS.

6.4.5 INACCURATE/INSUFFICIENT REPORTS

The Contractor will ensure that the reports submitted to DHS shall contain complete and accurate information as outlined in Attachment 9.4-B of the RFA.

Upon written notice by DHS that a report is insufficient or inaccurate, the Contractor will ensure that a corrected report is submitted to DHS within fifteen (15) days, or longer if allowed by DHS.

6.5 QUALITY IMPROVEMENT SYSTEM

6.5.1 GENERAL REQUIREMENT

The Contractor will monitor, evaluate, and take effective action to address any needed improvements in the Quality of Care delivered by all practitioners providing services on its behalf in all types of settings: ambulatory, impatient or home setting. The Contractor will be accountable for the quality of health care delivered whether it be preventive, primary, specialty, emergency, or ancillary care services regardless of the number of contracting and subcontracting layers between the Contractor and the individual practitioner delivering care to the Member.

6.5.1.1 WRITTEN DESCRIPTION

The Contractor will implement and maintain a written description of its QIP which will include the following:

A. Organizational commitment to deliver quality health care services, goals, and objectives including accreditation of its QIP program, which are evaluated and updated annually and include a time table for implementation and accomplishment.

B. Organizational chart showing the key persons, the committees and bodies responsible for Quality Improvement, reporting relationships of QIP committees within the Contractor's organization, and provisions for support staff including reporting relationships.

C. Qualifications of staff responsible for Quality Improvement studies and activities including appropriate education, experience and training.

D. The QIP scope of review, which must include:

1. Quality of clinical care services including, but not limited to, preventive services, prenatal care, and family planning services.

2. Quality of nonclinical services including, but not limited to, availability, accessibility, coordination and continuity of care.

3. Representation of the entire range of care provided by the Contractor including all demographic groups, care settings (e.g. Emergency Services, inpatient, ambulatory, and home health care) and types of services (e.g. preventive, primary, specialty and ancillary).

E. A description of specific Quality of Care studies and other activities to be undertaken over a prescribed period of time, the responsible individuals, organizational resources utilized to accomplish them, methodologies to be used, including but not limited to those that address health outcomes, and mechanisms for tracking issues over time.

F. A description of a system for provider review of the QIP which at a minimum demonstrates Physicians' and other professionals' involvement and provisions for providing feedback to staff and providers regarding performance and outcomes.

G. A description of the annual QIP report will include a summary of all QIP studies and other activities completed; trending of clinical and service indicators and other performance data; areas of deficiency and Corrective Actions undertaken; an evaluation of the overall effectiveness of the QIP and evidence that activities have contributed to significant improvements in care delivered to Members.

6.5.2 QIP ADMINISTRATIVE SERVICES

6.5.2.1 Accountability

The Contractor will maintain a system of accountability which includes the participation of the Governing Body of the Contractor's organization, the designation of a Quality Improvement Committee with oversight and performance responsibility, the supervision of activities by the Medical Director, the inclusion of contracted Physicians and other providers in the process of QIP development and performance review.

6.5.2.2 GOVERNING BODY

The Contractor will implement and maintain policies that specify the responsibilities of the Governing Body including at a minimum the following:

A. Approves the overall QIP and the annual report of the QIP.

B. Appoints an accountable entity or entities within the Contractor's organization to provide oversight of the QIP.

C. Routinely receives written progress reports from the QIP committee describing actions taken, progress in meeting QIP objectives, and improvements made.

D. Formally reviews, (at least annually), a written report on the QIP which includes; studies undertaken, results, subsequent actions, and aggregate data on Utilization and quality of services rendered; and assess the QIP's continuity, effectiveness, and current acceptability.

E. Directs the operational QIP to be modified on an ongoing basis, and tracks all review findings for follow-up.

6.5.2.3 QUALITY IMPROVEMENT COMMITTEE

The Contractor will implement and maintain a Quality Improvement Committee designated by, and accountable to the Governing Body. The role, structure, function of this committee will be delineated. The committee will meet at least quarterly but as frequently as necessary to demonstrate follow-up on all findings and required actions. On a scheduled basis the activities, findings, recommendations, and actions of the committee are reported to the Governing Body in writing. The Contractor will ensure that minutes of committee meetings are submitted to DHS quarterly for review. Subcontractors, who are representative of the composition of the contracted provider network, will actively participate in the Quality Improvement Committee. The Contractor will maintain a process to ensure confidentiality of QIP discussions as well as avoidance of conflict of interest on the part of the reviewer.

6.5.2.4 MEDICAL DIRECTOR

The Contractor will ensure that the Medical Director will be directly involved in the implementation of Quality Improvement activities.

6.5.2.5 PROVIDER PARTICIPATION

The Contractor will ensure that Physicians and other health care providers will be involved as an integral part of the Quality Improvement program. The Contractor will maintain and implement appropriate procedures to keep providers informed of the written QIP, its activities and outcomes. The Contractor will maintain employment agreements and provider contracts which include a requirement securing cooperation with the QIP. The Contractor will ensure that contracted hospitals and other subcontractors will allow the Contractor access to the Medical Records of its Members.

6.5.2.6 DELEGATION OF QIP ACTIVITIES

The Contractor is accountable for Quality Improvement even when it delegates Quality Improvement activities to its subcontractors. The Contractor will maintain a system to ensure accountability of delegated QIP activities including:

A. Maintenance of policies and procedures which describe delegated activities, QIP authority, function, and responsibility, how each subcontractor will be informed of its scope of QIP responsibilities, and the subcontractor's accountability for delegated activities.

B. Establish reporting standards to include findings and actions taken by the subcontractor as a result of the QIP activities with the reporting frequency to be at least quarterly.

C. Maintenance of written procedures and documentation of continuous monitoring and evaluation of the delegated functions, evidence that the actual Quality of Care being provided meets professionally recognized standards.

D. Assurance and documentation that the subcontractor has the administrative capacity, task experience, and budgetary resources to fulfill its responsibilities.

E. The Contractor will approve the delegate's QIP, including its policies and procedures which will meet standards set forth by the Contractor.

F. The Contractor will ensure that the actual Quality of Care being provided is being continuously monitored and evaluated.

6.5.2.7 COORDINATION WITH OTHER MANAGEMENT ACTIVITIES

The Contractor will implement and maintain Quality Improvement channels and facilitate coordination with other performance monitoring activities, including risk management and resolution and monitoring of Member complaints and Grievances. The Contractor's QIP will maintain linkages with other management functions such as network changes, medical management systems (i.e. pre-certification), practice feedback to Physicians, patient education/health education, Member services, and human resources feedback.

6.5.3 SYSTEMATIC PROCESS OF QUALITY IMPROVEMENT

6.5.3.1 GENERAL REQUIREMENTS

The Contractor's QIP will objectively and systematically monitor and evaluate the quality and appropriateness of care and services rendered on an ongoing basis. The Contractor will conduct Quality of Care studies that address the quality of clinical care as well as the quality of health services delivery. The Contractor will ensure that the studies reflect the population served in terms of age groups, disease categories and special risk status. These studies will continuously monitor care against practice guidelines or clinical standards and will use appropriate Quality Indicators as measurable variables. The Contractor will ensure that data collected will be analyzed by the appropriate health professionals, and system issues will be addressed by multi-disciplinary teams. The Contractor will undertake Corrective Actions whenever problems are identified. The Contractor will maintain a system for tracking the issues

over time to ensure that actions for improvement are effective.

6.5.3.2 QUALITY OF CARE STUDIES

The Contractor will perform eleven (11) focused studies on an ongoing basis as listed below:

A. Clinical Areas

1. Pediatric preventive services: immunizations and health screens.

2. Obstetrical care.

3. Adult preventive services.

B. Health Services Delivery Areas

1. Access to care.

2. Utilization of services.

3. Coordination of care.

4. Continuity of care.

5. Health Education.

6. Emergency Services.

7. Member satisfaction surveys.

8. Family planning.

6.5.3.3 STANDARDS AND GUIDELINES

The Contractor will use the following standards and guidelines for Preventive Care as designated by DHS. The Contractor will adopt these standards and guidelines as a baseline for assessment against which care actually delivered can be compared. For Quality of Care studies in the health services delivery areas, the Contractor will use the specific standards set forth in the pertinent subsections. The Contractor's Quality of Care studies may include health services delivery issues other than the eleven (11) priority areas identified. For other clinical or health services delivery areas where

DHS has not specified clinical standards or practice guidelines, the Contractor will submit these standards or guidelines to DHS for approval six weeks prior to conducting the studies.

A. Pediatric:

Periodic health screen schedule based on recommendations of the American Academy of Pediatrics (AAP) as specified in Title 17, CCR, Section 6800 et seq. Child Health and Disability Program (CHDP). Immunization schedule based on recommendations of either the Advisory Committee on Immunization Practices or the AAP will be acceptable.

B. Adult:

Guidelines based on the Report of the United States Preventive Services Task Force.

C. Obstetric:

Minimum standards based on recommendations of the American College of Obstetrics and Gynecology. Contractors are further required to provide risk assessment and interventions consistent with Comprehensive Perinatal Services Program (CPSP) requirements as specified in Title 22, CCR, Sections 51348 and 51348.1.

6.5.3.4 QUALITY INDICATORS

The Contractor will use the following Quality Indicators for the required studies in preventive services indicated in Section 6.5.3.3.

A. Pediatric preventive services:

Medi-Cal children who had received the required number of immunizations in the first two years of life.

B. Adult preventive services:

1. Medi-Cal women aged 52-64 who had at least one mammogram during the past two years.

2. Medi-Cal women aged 21-64 who had at least one Pap smear during the past 3 years.

3. Medi-Cal Members between ages 20 and 64 screened for cholesterol at least once in the past five years.

C. Pregnant Women

1. Medi-Cal pregnant Members who received adequate prenatal care based on:

   a. The month of pregnancy in which the beneficiary became a Member of the health plan.

   b. The month of pregnancy in which the initial comprehensive medical/OB visit occurred for each pregnant Member.

   c. The number of pregnancy related medical/OB visits during pregnancy, exclusive of delivery for each pregnant woman.

   d. The delivery date for each pregnant Member.

2. Outcomes:

   a. Medi-Cal pregnant women who delivered live births (single or multiple), or still born greater than 20 weeks gestation; by age, race/ethnicity, and risk status (high risk vs. others).

   b. Live born infants greater than or equal to 20 weeks gestation (linked to a Medi-Cal pregnant Member) who weighs:

      1. Up to 1499 grams (VLBW).

      2. 1500 - 2499 grams (LBW).

      3. 2500 - 4000 grams

      4. > 4000 grams

6.5.3.5 REPORTS

The Contractor will initiate all Quality of Care studies within six months of operation and the progress and/or results of these Quality of Care studies will be submitted to DHS contract managers six months after initiation of the study (due fifteen (15) days after the end of the first year of operation) and at least quarterly updates thereafter.

Quarterly updates will be due fifteen (15) days after the end of the quarter.

6.5.4 CREDENTIALING AND RECREDENTIALING

6.5.4.1 GENERAL REQUIREMENTS

The Contractor will develop, and maintain written policies and procedures which include initial Credentialing, recredentialing, recertification, and reappointment of practitioners. Contractor will ensure that policies and procedures are reviewed and approved by the Governing Body, or its designee. Contractor will ensure that the responsibility for recommendations regarding Credentialing decisions will rest with a Credentialing committee or other peer review body.

6.5.4.2 CREDENTIALING

Contractor will ensure that the initial Credentialing process obtains and verifies the following information:

A. A current valid license, registration or certificate to practice, a valid Drug Enforcement Agency registration number as applicable.

B. Graduation from a medical school, completion of a residency, Board certified or Board eligible as applicable; education as required.

C. Clinical privileges in good standing at the hospital designated by the practitioner as the primary admitting Facility (this requirement may be waived for practices which do not have or do not need access to hospitals), includes review of past history of curtailment or suspension of medical staff privileges.

D. Work history.

E. Professional liability claims history.

F. Requested information from: National Practitioner Data Bank and the Medical Board of California (MBC).

G. Any sanctions imposed by Medi-Cal, Medicaid and Medicare.

H. A signed statement by the practitioner at time of application regarding any physical or mental health problems, any history of chemical dependency/substance abuse, history of loss of license and/or felony convictions, history of loss or limitation of privileges or disciplinary actions.

As part of the initial Credentialing procedure, the Contractor will conduct site reviews of each potential Primary Care Physician's office.

6.5.4.3 RECREDENTIALING

The Contractor will develop and maintain policies and procedures delineating the process for periodic reverification of clinical credentials. The Contractor will ensure that recredentialing occurs at least every two years. The Contractor will ensure that the process includes a review of all areas reviewed for Credentialing, excluding previously researched past history, a performance review which includes data from Member complaints, results of quality reviews, Utilization management, Member satisfaction surveys, and a site visit to Primary Care Physicians' Facilities will also be included in the recredentialing process.

6.5.4.4 DELEGATED CREDENTIALING

The Contractor will ensure the qualifications of all network practitioners, approve new providers and sites, and terminate or suspend individual providers. The Contractor may delegate Credentialing and recredentialing activities but will monitor the completion and effectiveness of the delegated process, If the Contractor delegates Credentialing and recredentialing activities, the Contractor will implement and maintain policies and procedures which delineate the delegated activities and responsibility for these activities.

6.5.4.5 DISCIPLINARY ACTIONS

The Contractor will implement and maintain a system for the reporting of serious quality deficiencies which result in suspension or termination of a practitioner to the appropriate authorities. The Contractor will implement and maintain policies and procedures for disciplinary actions including, reducing, suspending, or terminating a practitioner's privileges. Contractor will implement and maintain a provider appeal process. The Contractor will ensure that any providers impacted by adverse determinations will be provided due process through the Contractor's provider appeal process.

6.5.5 FACILITY REVIEW

6.5.5.1 GENERAL REQUIREMENT

The Contractor will conduct Facility reviews on all Primary Care Provider's sites as part of the Credentialing procedures.

6.5.5.2 REVIEW PROCEDURES

The Contractor will ensure that its Facility review procedures will be submitted to DHS for approval prior to use and will comply with all of DHS requirements which include the following categories:

A. Front office procedures including:

1. Telephone access, triage/advice.

2. Appointment scheduling.

3. Missed appointment and follow-up.

4. Referral appointment and follow-up.

5. Referral (consultation) reports, lab and X-ray follow-up.

B. Fire and disaster plan.

C. Infection control.

D. Handling of bio-hazardous wastes.

E. Health education.

F. Medical emergencies.

G. Pharmacy policies (including handling of sample drugs).

H. Medical Records storage and filing.

I. Medical Records documentation.

J. Grievances.

K. Laboratory services.

L. Radiological services.

M. Preventive services for children, adults and pregnant women.

N. Facility access for physically disabled individuals.

O. Human sterilization consent procedures.

6.5.5.3 NUMBER OF SITES TO BE REVIEWED PRIOR TO OPERATIONS

The Contractor will ensure that Facility reviews are completed on at least 25 % of the total number of Primary Care sites or a minimum of 30 sites prior to initiating plan operation or new site expansion. Contractors with 30 sites or less, will complete Facility reviews on all sites prior to initiating operation. The Contractor with NCQA or JCAHO accreditation is exempted from this requirement.

6.5.5.4 NUMBER OF SITES TO BE REVIEWED AFTER OPERATIONS BEGIN

The Contractor, regardless of NCQA or JCAHO accreditation, will complete Facility reviews on all (100%) Primary Care sites within 6 months after plan operation and will conduct ongoing Facility reviews as part of the recredentialing process.

6.5.5.5 DHS FACILITY INSPECTIONS

Contractor will provide any necessary assistance to DHS in its conduct of Facility inspections and medical reviews of the Quality of Care being provided to Members. Contractor will ensure correction of deficiencies as identified by those inspections and reviews according to the frames delineated in the resulting reports.

6.5.5.6 CORRECTIVE ACTIONS

The Contractor will take Corrective Actions if a DHS inspection finds a Primary Care site to be in substantial non-compliance. Contractor will ensure that Primary Care sites with major, uncorrected deficiencies are not allowed to begin operation.

6.5.5.7 CONTINUING OVERSIGHT

The Contractor will remain responsible for the oversight and monitoring of delegated Facility review activities.

6.5.6 MEMBERS RIGHTS AND RESPONSIBILITIES

6.5.6.1 GENERAL REQUIREMENT

The Contractor will develop, implement and maintain written policies that address the Member's rights and responsibilities and will communicate these to its Members and providers.

6.5.6.2 WRITTEN POLICY: MEMBER'S RIGHTS

The Contractor's written policy regarding Member rights will include the Member's right to be treated with respect, to be provided with information about the organization and its services, to be able to choose a Primary Care Physician within the Contractor's network, to participate in decision making regarding their own health care, to voice Grievances about the organization or the care received, to formulate advance directives, to have access to family planning services, FQHC, Indian Health, STD services and Emergency Services outside the Contractor's network pursuant to the federal law, the right to request a fair hearing, to have access to their Medical Record, and to disenroll.

6.5.6.3 WRITTEN POLICY: MEMBER'S RESPONSIBILITY

The Contractor's written policy regarding Member responsibilities will include providing accurate information to the professional staff, following instructions, and cooperating with the providers.

6.5.6.4 MEMBER'S GRIEVANCE SYSTEM

The Contractor will implement and maintain procedures to monitor the Members' Grievance system which includes:

A. Procedure to ensure timely resolution and feedback to complainant. The Contractor will acknowledge receipt of the complaint within 5 days and resolve the complaint within 30 days or document reasonable efforts to resolve the complaint.

B. Procedure for systematic aggregation and analysis of the Grievance data and use for Quality Improvement.

C. Procedure to ensure that the Grievance submitted is reported to an appropriate level, i.e., medical issues versus health care delivery issues.

6.5.6.5 MEMBER'S RIGHT TO CONFIDENTIALITY

The Contractor will implement and maintain policies and procedures to ensure the Members' right to confidentiality of medical information.

A. The Contractor will ensure that Facilities implement and maintain procedures that guard against disclosure of confidential information to unauthorized persons inside and outside the network.

B. Contractor will counsel Members on their right to confidentiality and the Contractor will obtain Member's consent prior to release of confidential information.

C. The Contractor will implement and maintain procedures to ensure the Members' confidentiality when accessing Sensitive Services such as family planning, STD, abortion and HIV testing.

6.5.6.6 MINOR'S RIGHTS AND SERVICES

The Contractor will implement and maintain policies and procedures on providing treatment services to minors and their right to access Minor Consent Services.

6.5.6.7 MEMBER SATISFACTION SURVEYS

The Contractor will conduct surveys of Member satisfaction with its services, at least annually:

A. At a minimum, the surveys will include the following groups of Members: Members filing Grievance/complaints, Members requesting change of providers or Facilities, groups who speak a primary language other than English meeting threshold levels, and Members requesting Disenrollment from the Contractor.

B. The Contractor's Member survey will identify perceived problems in quality, availability and accessibility of care as well as reasons for Member's accessing care from an out-of-plan provider, e.g., family planning services.

C. The Contractor will use the survey to identify sources of dissatisfaction, outline action steps to follow up on the findings, inform providers of the results, and reevaluate the effects of the actions taken.

6.5.7 AVAILABILITY AND ACCESSIBILITY

6.5.7.1 GENERAL REQUIREMENT

The Contractor will implement and maintain procedures for Members to obtain appointments for routine care, Urgent Care, emergency care, prenatal care, CHDP periodic health screens, adult initial health assessments, and procedures for obtaining appointments with specialists.

6.5.7.2 EMERGENCY CARE

The Contractor will ensure that a Member with an Emergency Condition as defined in Article II, Definitions, will be seen immediately and Emergency Services will be available and accessible within the Service Area 24 hours a day. The Contractor will ensure adequate follow-up care for those Members who require non-emergent care and who are denied services in the emergency room.

6.5.7.3 URGENT CARE

The Contractor will ensure that a Member needing Urgent Care will be seen within 48 hours upon request.

6.5.7.4 FIRST PRENATAL VISIT

The Contractor will ensure that the first prenatal visit for a pregnant Member will be available within a week upon request.

6.5.7.5 WAITING TIMES

The Contractor will develop, implement, and maintain a procedure to monitor waiting times in the providers' offices, telephone calls (to answer and return), and in obtaining various types of appointments as indicated in Section 6.5.7.1.

6.5.7.6 TELEPHONE PROCEDURES

The Contractor will maintain a procedure for triaging Members' telephone calls and providing telephone medical advice.

6.5.7.7 AFTER HOURS CALLS

At a minimum, Contractor will ensure that a Physician or a Nurse under his (her) supervision will be available for after-hours calls.

6.5.7.8 SENSITIVE SERVICES

The Contractor will implement and maintain procedures to ensure ready access to Sensitive Services for adult and adolescent Members. Adolescent Members will be able to access Sensitive Services without parental consent and through a provider other than the Primary Care Physician if so requested. Adults will be able to access Sensitive Services in a timely manner and without barriers such as Prior Authorization requirements.

6.5.7.9 ACCESS FOR DISABLED MEMBERS

The Contractor's Facilities will comply with the requirements of Title III of the Americans with Disabilities Act of 1990, and will ensure access for the disabled which includes, but is not limited to, ramps, elevators, restrooms, designated parking spaces, and drinking water provision.

6.5.7.10 UNUSUAL SPECIALTY SERVICES

The Contractor will arrange for the provision of seldom used or unusual specialty services from specialists outside the network when determined Medically Necessary.

6.5.8 MEDICAL RECORDS

6.5.8.1 GENERAL REQUIREMENT

The Contractor will ensure that appropriate Medical Records for the Member will be available to health care providers at each Encounter.

6.5.8.2 MEDICAL RECORDS PROCEDURES

The Contractor will implement and maintain the following:

A. Procedures for storage and filing of Medical Records including: collection, processing, maintenance, storage, retrieval identification, and distribution.

B. A written policy to ensure that Medical Records are protected and confidential.

C. Written procedures for release of information and obtaining consent for treatment.

D. Policies and procedures to ensure maintenance of Medical Records in a legible, current, detailed, organized and comprehensive manner (records may be electronic or hard copy).

6.5.8.3 ON-SITE MEDICAL RECORDS

The Contractor will ensure that an individual will be delegated the responsibility of securing and maintaining Medical Records at each site.

6.5.8.4 MEMBER MEDICAL RECORD

The Contractor will ensure that a complete Medical Record will be maintained for each Member in accordance with Title 22, CCR, Section 53284, and it will reflect all aspects of patient care, including ancillary services, and at a minimum will include:

A. Member identification on each page; personal/biographical data in the record.

B. All entries dated and author identified; the entries will include at a minimum, the subjective complaints, the objective findings, and the plan for diagnosis and treatment.

C. The record will contain a problem list, a complete record of immunizations and health maintenance or preventive services rendered.

D. Allergies and adverse reactions are prominently noted in the record.

E. All informed consent documentation, including the human sterilization consent procedures required by Title 22, CCR, Sections 51305.1 through 51305.6, if applicable.

F. All emergency care provided (directly by the contracted provider or through a emergency room) and the hospital discharge summaries for all hospital admissions while the patient is enrolled.

G. All consultations, referrals, and specialists' reports, and all pathology and laboratory reports. Any abnormal results will have an explicit notation in the record.

H. For Medical Records of adults, documentation of whether the individual has been informed and has executed an advanced directive such as a Durable Power of Attorney for Health Care.

I. Request or refusal of language/interpretation services.

J. Health education behavioral assessment and referrals to health education services. For patients 12 years or older, a notation concerning use of cigarettes, alcohol, and substance abuse, health education or counseling and anticipatory guidance.

6.5.8.5 MEDICAL RECORDS REVIEW

The Contractor will implement and maintain a system to review records for compliance with Medical Records standards, and institute a Corrective Action when necessary. The Contractor will ensure that Medical Records will be reviewed for:

A. Uniformity of forms.

B. Legibility (the record is legible to a person other than the writer).

C. Completeness.

D. Quality and appropriateness of services provided.

E. Immunizations.

F. Preventive health screening.

6.5.9 UTILIZATION MANAGEMENT

6.5.9.1 GENERAL REQUIREMENT

The Contractor will develop, implement and maintain a Utilization Management (UM) program which includes list of services that require Prior Authorization, persons responsible for UM and their qualifications, procedures to evaluate Medical Necessity, criteria used for approval, referral and denial of services, information sources, and the process used to review and approve the provision of medical services.

6.5.9.2 UNDER AND OVER-UTILIZATION

The Contractor will ensure that the UM program has mechanisms to detect both under and over-utilization of services.

6.5.9.3 PRE-AUTHORIZATION/REVIEW PROCEDURES

The Contractor will ensure that its pre-authorization and concurrent review procedures will meet the following minimum requirements:

A. Review decisions are supervised by qualified medical professionals and all denials will be reviewed by a qualified Physician.

B. There is a set of written criteria or guidelines for Utilization Review that is based on sound medical evidence, is updated regularly and consistently applied.

C. Reasons for decisions are clearly documented.

D. There is a well-publicized appeals procedure for both providers and patients.

E. Decisions and appeals are made in a timely manner.

6.5.9.4 EXCEPTIONS TO PRIOR AUTHORIZATION REQUIREMENT

The Contractor will ensure that Prior Authorization requirements are not applied to Emergency Services, family planning services, preventive services, sensitive and confidential services and basic prenatal care.

6.5.9.5 DELEGATING UM ACTIVITIES

Contractor will ensure that delegated UM activities to subcontractors are approved and regularly evaluated. Contractor will ensure that this process is documented.

6.5.10 CONTINUITY OF CARE AND CASE MANAGEMENT

6.5.10.1 MEDICAL CASE MANAGEMENT

The Contractor will provide basic medical case management to each Member.

6.5.10.2 INITIAL HEALTH ASSESSMENT

The Contractor will develop, implement, and maintain procedures for the performance of initial health assessment for each Member within 120 days of Enrollment.

6.5.10.3 REFERRALS AND FOLLOW-UP CARE

The Contractor will develop, implement, and maintain an adequate system for tracking all referrals and follow-up care.

6.5.10.4 COORDINATION OF CARE

The Contractor will maintain procedures for monitoring the coordination of care provided to the Member, including but not limited to coordination of discharge planning from inpatient Facilities, and coordination of all Medically Necessary services both within and outside the Contractor's provider network.

6.5.10.5 MISSED/BROKEN APPOINTMENTS

The Contractor will implement and maintain policies and procedures to follow-up on missed/broken appointments.

6.5.10.6 CONTINUITY OF CARE

The Contractor will ensure continuity of care from the Ambulatory Care setting to the inpatient care setting.

6.5.11 INPATIENT CARE

6.5.11.1 GENERAL REQUIREMENT

The Contractor will implement and maintain procedures to monitor Quality of Care provided in an inpatient setting to its Members. If the Contractor delegates the QI functions to hospitals, the Contractor will maintain procedures to monitor the delegated function, including review of services provided by its Physicians within the hospital.

6.5.12 INFECTION CONTROL

6.5.12.1 INFECTION CONTROL PLAN

The Contractor will implement and maintain an effective plan for the surveillance, prevention and control of infection. The Contractor will ensure that this plan will include the scope (both patient care and support services) the persons responsible, the policies and procedures and frequency of review (at least every 2 years), the role and responsibilities of each service, the monitoring activities, and approval by the Governing Body.

6.5.12.2 INFECTION CONTROL POLICIES AND PROCEDURES

The Contractor will implement and maintain policies for prevention and control of infection transmission in patients and personnel which include:

A. Application of universal precaution procedures.

B. The availability of adequate infection control devices and supplies in the patient areas.

C. Infectious or biohazardous waste disposal procedures complying with applicable State and federal regulations.

D. Isolation precautions and procedures.

E. Cleaning and sterilization methods, agents, and schedules; including maintenance of autoclave, spore testing, storage of sterile packs, etc.

F. Training and continuing education of all personnel.

6.5.12.3 REVIEW OF PATIENT INFECTIONS

The Contractor will ensure the review of patient infections that present the potential for prevention or intervention to reduce the risk of future occurrence.

6.5.12.4 REPORTING PROCEDURES

The Contractor will implement and maintain a procedure for reporting infectious diseases to public health authorities as required by State law.

6.5.12.5 SUBCONTRACTS

The Contractor will ensure that its infection control policies are communicated to its subcontractors and monitor its subcontractors for compliance.

6.6 PROVIDER NETWORK AND GEOGRAPHIC ACCESS

6.6.1 TIME AND DISTANCE STANDARD

Contractor will maintain a network of Primary Care Physicians which are located within thirty (30) minutes or ten (10) miles of a Member's residence unless the Contractor has a DHS approved alternative time and distance standard.

6.6.2 NETWORK CAPACITY

The Contractor will maintain a provider network adequate to serve sixty percent (60%) of the Eligible Beneficiaries in the proposed county and provide the full scope of benefits. Contractor will increase the capacity of the network as necessary to accommodate Enrollment growth beyond the sixty percent (60%). However, after the first twelve months of operation, if Enrollments do not achieve seventy-five (75%) of the required network capacity, the Contractor's total network capacity requirement may be renegotiated.

6.6.3 NETWORK COMPOSITION

The Contractor will maintain an adequate number of inpatient Facilities, Service Locations, Service Sites, professional, allied, specialist and supportive paramedical personnel within their network to provide Covered Services to its Members.

6.6.4 ACCESS REQUIREMENTS

The Contractor will ensure Members access to all Medically Necessary specialists through staffing, subcontracting, or referral. Contractor will ensure adequate staff within the Service Area, including Physicians, administrative and other support staff directly and/or through Subcontracts, sufficient to assure that health services will be provided consistent with all specified requirements.

6.6.5 SPECIALISTS

The Contractor will maintain adequate numbers and types of specialists within their network to accommodate the need for specialty care. Contractor will provide a recording/tracking mechanism for each authorized, denied, or modified referral. In addition, the Contractor will offer second opinions by Specialists to any Member upon request.

6.6.6 PROVIDER TO MEMBER RATIOS

The Contractor will ensure that networks will satisfy the following full time equivalent provider to Member ratios:

A.	Primary Care Physicians	1:2,000
B.	Total Physicians	1:1,200
C.	Non-Physician Medical Practitioner	1:1,000

6.6.7 PHYSICIAN SUPERVISOR TO NON-PHYSICIAN MEDICAL PRACTITIONER RATIOS

Contractor will ensure compliance with Title 22, CCR, Sections 51240 and 51241, and that full time equivalent Physician Supervisor to Non-Physician Medical Practitioner ratios do not exceed the following:

A. Nurse Practitioners 1:4
B. Midwives 1:3
C. Physician Assistants 1:2
D. Four (4) Non-Physician Medical Practitioners in any combination that does not include more than three nurse midwives or two physician assistants and maintains the full time equivalence limits.

6.6.8 SUBCONTRACTS

The Contractor will execute Subcontracts pursuant to the requirements contained in Article III, Section 3.27, Subcontracts and Title 22, CCR, Section 53250.

6.6.9 TRADITIONAL AND SAFETY-NET PROVIDERS PARTICIPATION

The Contractor will ensure the participation and broad representation of traditional and safety-net providers within the county. Federally Qualified Health Centers meet the definitions of both traditional and safety-net providers.

6.6.10 TRADITIONAL AND SAFETY-NET PROVIDER CAPACITY

The Contractor will maintain the percentage of traditional and safety-net provider capacity submitted and approved by DHS.

6.6.11 EXISTING PATIENT-PHYSICIAN RELATIONSHIPS

The Contractor will ensure that no traditional or safety-net provider, upon entry into the Contractor's network, suffers any disruption of existing patient-physician relationships, to the maximum extent possible. The Contractor will ensure that Members may choose traditional and safety-net providers as their Primary Care Physician. Contractor will submit a plan that proportionately includes contracting traditional and safety-net providers in the assignment process for Members who do not choose a Primary Care Physician.

6.6.12 MONTHLY REPORT

The Contractor will submit to DHS on a monthly basis, in a format specified by DHS, a report summarizing changes in the provider network. The report will identify provider deletions and additions and the resulting impact to: 1) geographic access for the Members; 2) cultural and linguistic services; 3) the targeted percentage of traditional and safety-net providers; 4) the ethnic composition of providers; and 5) the number of Members assigned to Primary Care Physicians and the percentage of Members assigned to traditional and safety-net providers. The Contractor will submit the report thirty (30) days following the end of the reporting month.

6.6.13 CONTRACT AND EMPLOYMENT TERMINATIONS

Contractor will also ensure that provider contract or employment terminations do not adversely affect the ethnic composition of their provider network.

6.6.14 UTILIZATION OF DSH HOSPITALS

The Contractor will increase Utilization of Disproportionate Share Hospitals by Members to a level specified by DHS upon notification. DHS will only impose this requirement if the Utilization of Disproportionate Share Hospitals has decreased in such magnitude as to jeopardize disproportionate status of hospitals in the county.

6.6.15 ADEQUATE FACILITIES AND PERSONNEL

Contractor will demonstrate the continuous availability and accessibility of adequate numbers of institutional Facilities, Service Locations, Service Sites, and professional, allied, and supportive paramedical personnel to provide Covered Services including the provision of all medical care necessary under emergency circumstances on a 24-hour-a-day, 7-day-a-week basis. The Contractor will ensure that a plan Physician is available 24 hours a day for timely authorization of Medically Necessary care and to coordinate transfer of stabilized Members in the emergency department, if necessary. The Contractor will have as a minimum a designated Emergency Services Facility, providing care on a 24-hour-a-day, 7-day-a-week basis. This designated Emergency Services Facility will have one or more Physicians and one Nurse on duty in the Facility at all times.

6.6.16 EMERGENCY SERVICE PROVIDERS

Contractor will pay for Emergency Services received by a Member from non-Contractor providers. Payments to non-Contractor providers will be for the treatment of the emergency medical condition including Medically Necessary services

rendered to a Member until the Member's condition has stabilized sufficiently to permit discharge, or referral and transfer in accordance with instructions from the Contractor. Emergency Services will not be subject to Prior Authorization by the Contractor.

The Contractor will pay for those services provided by a non-Contractor emergency department (ED) that are required to determine whether treatment of the Member's condition qualifies as an Emergency Service. At a minimum, the Contractor must reimburse the non-Contractor ED and, if applicable, its affiliated providers for Physician services at the lowest level of evaluation and management CPT (Physician's Current Procedural Terminology) codes, unless a higher level is clearly supported by documentation, and for the Facility fee and diagnostic services such as laboratory and radiology.

Payment by the Contractor for properly documented claims for services rendered by a non-Contractor provider pursuant to this section will be made in accordance with Article III, Section 3.27.9, and will not exceed the lower of the following rates applicable at the time the services were rendered by the provider:

A. The usual charges made to the general public by the provider.

B. The maximum Fee-For-Service rates for similar services under the Medi-Cal Program.

Disputed claims may be submitted to DHS for resolution under the provisions of Section 14454, W&I Code and Title 22, CCR, Sections 53620 through 53702. The Contractor agrees to abide by the findings of DHS in such cases, to promptly reimburse the non-Contractor provider within 30 days of the effective date of a decision that the Contractor is liable for payment of a claim and to provide proof of reimbursement in such form as the Director may require. Failure to reimburse the non-Contractor provider and provide proof of reimbursement to DHS within 30 days will result in liability offsets in accordance with Title 22, CCR, Section 53702.

6.6.17 USERS MANUAL AND BULLETINS

Contractor will issue a Users Manual and Bulletins (updates) to the providers of Medi-Cal services. The manual and bulletins shall serve as a source of information to health care providers regarding Medi-Cal services, policies and procedures, statutes, regulations, telephone access and special requirements.

6.6.18 PROVIDER TRAINING

Contractor will ensure that all providers receive training regarding the Medi-Cal Managed Care program in order to operate in full compliance with the Contract and all applicable Federal and State regulations. Contractor will ensure that provider training relates to Medi-Cal Managed Care services, policies, procedures and any modifications to existing services, policies or procedures. Contractor will conduct training for all providers within ten (10) days after the Contractor places a newly contracted provider on active status. Contractor will ensure that ongoing training is conducted when deemed necessary by either the Contractor or the State.

6.6.19 FQHC SERVICES

Contractor will meet federal requirements for access and reimbursement for FQHC services, including those in 42 United States Code Section 1396 b(m) and Medicaid Regional Memorandum 93-13. If FQHC services are not available in the provider network of either Medi-Cal managed care contractor in the county, the Contractor will reimburse FQHCs for services provided out-of-plan to the Contractor's Members at the interim FQHC rate determined by DHS.

For family planning and Emergency Services, the provisions of Sections 6.6.16 and 6.7.4.5 through 6.7.4.9 apply.

6.6.20 FQHC SUBCONTRACTS

Any Subcontract with an FQHC will specify reimbursement on the basis of reasonable cost or at-risk capitation, and notwithstanding Article III, Section 3.27.4, the Contractor will submit it to DHS for approval of the reimbursement provision prior to implementation.

If the Subcontract reimbursement is based on reasonable cost, the Contractor will demonstrate that the rate to be paid by the Contractor is a reasonable equivalent to the interim FQHC rate determined by DHS. The Subcontract will specify that the reimbursement from the Contractor does not constitute payment in full to the FQHC and that the FQHC will be entitled to cost reconciliation by DHS. The Subcontract will also require the FQHC to keep a record of the number of visits by plan Members separate from FFS Medi-Cal beneficiaries, in addition to any other data reporting requirements. DHS will perform the reconciliation to determine the FQHC's reasonable costs and will pay to or recover from the FQHC the difference between the amount reimbursed by the Contractor and the FQHC's reasonable costs.

If the subcontract reimbursement is at-risk capitation, the Subcontract must specify that the capitation is total payment. If reimbursement is at-risk capitation, DHS will not perform the reconciliation and will not pay the FQHC's reasonable costs.

6.6.21 INDIAN HEALTH SERVICES FACILITIES

The Contractor will reimburse out-of-plan Indian Health Service Facilities for services provided to Members who are qualified to receive services from an Indian Health Service Facility. The Contractor will reimburse the out-of-plan Indian Health Service Facility at the approved Medi-Cal rate for that Facility.

The requirements in Section 6.6.19 apply to any Indian Health Service Facility which is also an FQHC.

6.6.22 VISION CARE SERVICES

Contractor will ensure a vision care services system, consistent with good professional practice, which provides that a Member may be seen initially by either of the following:

A. An optometrist or an ophthalmologist.

B. A Primary Care Physician before referral to an optometrist or an ophthalmologist.

Contractor will provide ophthalmic lenses in accordance with Section 6.7.3.6.

6.6.23 SUBCONTRACTOR SERVICES

The Contractor will not prohibit any subcontractor from providing services to Medi-Cal beneficiaries who are not Members of the Contractor's plan.

6.6.24 EMERGENCY DEPARTMENT PROTOCOLS

Contractor will develop and maintain protocols for communicating and interacting with emergency departments. Protocols will be distributed to all emergency departments in the contracted Service Area and will include at a minimum the following:

A. Description of telephone access, triage and advice systems used by the Contractor.

B. A plan contact person responsible for coordinating services that can be accessed 24 hours a day.

C. Process for rapid interfacing with emergency care systems.

D. Referral procedures (including after-hours instruction) which emergency department personnel can provide to Medi-Cal Members who present at the emergency department for non-emergency services.

E. Procedures for emergency departments to report system and/or protocol failures and process for ensuring Corrective Action.

6.7 SCOPE OF SERVICES/MEDICAL STANDARDS/HEALTH EDUCATION

6.7.1 COVERED SERVICES

6.7.1.1 GENERAL REQUIREMENTS

The Contractor will provide or arrange for all Medically Necessary Covered Services for Members. Covered Services are those services set forth in Title 22, CCR, Chapter 3, Article 4, beginning with Section 51301 and Title 17, CCR, Division 1, Chapter 4, Subchapter 13, beginning with Section 6840, unless otherwise specifically excluded under the terms of this Contract. The Contractor will ensure that the medical necessity of Covered Services is determined through Utilization control procedures established in accordance with Sections 6.5.9.3 and 6.5.9.4, unless specific Utilization control requirements are included as a term of the Contract under sections applicable to specific services.

6.7.1.2 REFERRAL SERVICES

The Contractor will arrange for the timely referral and coordination of those services to which the Contractor or subcontractor has religious or ethical objections to perform or otherwise support and will demonstrate ability to arrange, coordinate and ensure provision of services through referrals at no additional expense to DHS.

6.7.2 EXCLUDED SERVICES: CIRCUMSTANCES UNDER WHICH MEMBER DISENROLLED

6.7.2.1 MAJOR ORGAN TRANSPLANTS

Major organ transplant procedures are not covered under the Contract. These procedures are bone marrow transplants, heart transplants, liver transplants, lung transplants, heart/lung transplants, combined liver and kidney transplants, combined liver and small bowel transplants.

When a Member is identified as a potential transplant candidate, the Contractor will refer the Member to a Medi-Cal approved transplant center. If the transplant center Physician considers the Member to be a suitable candidate, the Contractor will submit a Prior Authorization Request to either the Medi-Cal Field Office (for adults) or the California Children Services Program (for children) for approval. The Contractor will initiate Disenrollment of the Member when all of the following has occurred: referral of the Member to the organ transplant Facility, the Facility's evaluation concurred that the Member is a candidate for an organ transplant and the transplant is authorized by either DHS' Medi-Cal Field Office (for adults) or the California Children Services Program (for children).

Upon Disenrollment, the Contractor will ensure continuity of care by transferring all of the Member's medical documentation to the transplant Physician. The effective date of the Disenrollment will be retroactive to the beginning of the month in which the transplant is approved. All services provided during this month will be billed FFS.

If the Member is evaluated and determined not to be a candidate for a major organ transplant or DHS denies authorization for a transplant, the Member will not be disenrolled. The cost of the evaluation and responsibility for the continuing treatment of the Member will remain with the Contractor.

6.7.2.2 WAIVER PROGRAMS

The Contractor will maintain systems for identifying and referring Members to the appropriate waiver program. If the agency administering the waiver program concurs with the Contractor's assessment of the Member and there is available placement in the waiver program, the Contractor will initiate Disenrollment for the Member. The Contractor will provide documentation to ensure the Member's orderly transfer to the Medi-Cal Fee-For-Service program. If the Member does not meet the criteria for the waiver program, or if placement is not available, the Contractor will continue to case manage and provide all Medically Necessary services to the Member.

6.7.2.3 LONG TERM CARE (LTC)

Contractor will ensure that Members, other than Members requesting hospice services, in need of nursing Facility services are placed in Facilities providing the appropriate level of care commensurate with the Member's medical needs. These Facilities include Skilled Nursing Facilities, subacute Facilities, pediatric subacute Facilities, and Intermediate Care Facilities. The Contractor will base decisions on the appropriate level of care on the definitions set forth in Title 22, CCR, Sections 51118, 51120, 51120.5, 51121, 51124.5, and 51124.6 and the criteria for admission set forth in Title 22, CCR, Sections 51335, 51335.5, 51335.6, and 51334 and related sections of the Manual of Criteria for Medi-Cal Authorization referenced in Title 22, CCR, 51003(e).

The Contractor will assess the projected length of stay of the Member upon admission to an appropriate Facility. If the Member will require long term care, care in the Facility for longer than the month of admission plus one month, the Contractor will submit a Disenrollment request for the Member to DHS for approval. The Contractor will provide all Medically Necessary Covered Services to the Member until the Disenrollment is effective. An approved Disenrollment request will become effective the first day of the second month following the month of the Member's admission to the Facility, provided the Contractor submitted the Disenrollment request at least 30 days prior to that date. If the Contractor submitted the Disenrollment request less than 30 days prior to that date, Disenrollment will be effective the first day of the month that begins at least 30 days after submission of the Disenrollment request. Upon Disenrollment, the Contractor will ensure the Member's orderly transfer from the Contractor to the Medi-Cal Fee-For-Service program.

Admission to a nursing Facility of a Member who has elected hospice services as described in Title 22, CCR, Section 51349, does not affect the Member's eligibility for Enrollment under this Contract. Hospice services are Covered Services under this Contract and are not long term care services regardless of the Member's expected or actual length of stay in a nursing Facility.

6.7.3 EXCLUDED SERVICES: CIRCUMSTANCES UNDER WHICH MEMBER ENROLLED WITH SERVICE CARVE OUT

6.7.3.1 MISCELLANEOUS SERVICE CARVE OUTS

Acupuncture services, adult day health care services, chiropractic services, and healing by prayer or spiritual means are not Covered Services under this Contract. The Contractor may, upon request, refer Members to these services.

Local Education Agency (LEA) assessment services provided to any student and any LEA services provided pursuant to an Individual Education Plan (IEP) or Individual Family Service Plan (IFSP) are not covered under the Contract.

6.7.3.2 CALIFORNIA CHILDREN SERVICES (CCS)

CCS services are not covered under this Contract. The Contractor will identify children with CCS eligible conditions, arrange for their referral to the local CCS office, and will continue to provide case management of the children until eligibility is established with the CCS program. The Contractor will provide Primary Care and other services unrelated to the CCS eligible condition and will ensure the coordination of services between its Primary Care Providers, the CCS specialty providers, and the local CCS program.

6.7.3.3 MENTAL HEALTH

The following mental health services are excluded from the Contract: all of SD/MC mental services (inpatient and outpatient); FFS/MC outpatient mental health services provided by psychiatrists and psychologists; FFS/MC inpatient mental health services. Effective June 1, 1996 all psychotherapeutic drugs prescribed by psychiatrists will be excluded.

The Contractor will provide outpatient mental health services within the Primary Care Physician's scope of practice. The Contractor will refer Members who need specialty mental health services to the appropriate FFS/MC mental health provider or to the appropriate SD/MC provider. The Contractor will case manage the physical health of the Member and coordinate services with the mental health provider of the Member. Effective June 1, 1996 the Contractor will provide all psychotherapeutic drugs prescribed by its primary care physicians, but will not longer be responsible for psychotherapeutic drugs prescribed by psychiatrists.

6.7.3.4 ALCOHOL AND DRUG TREATMENT SERVICES

Alcohol and drug treatment services available under the Short-Doyle Medi-Cal (SD/MC) program as defined in Title 22, CCR, Section 51341(a) and (c) and outpatient heroin detoxification as defined in Title 22, CCR, Section 51328 are excluded from this Contract.

The Contractor will arrange and coordinate Medically Necessary services, including referral of Members requiring alcohol and drug treatment to SD/MC alcohol and drug treatment programs including outpatient heroin detoxification providers. The Contractor will assist Members in locating available treatment Service Sites. To the

extent that treatment slots are not available within the Contractor's geographical Service Area, the Contractor is encouraged to pursue placement outside the area.

6.7.3.5 DENTAL

Dental services are not covered under this Contract. The Contractor will perform dental screening for all Members as part of the initial health assessment and refer Members to Medi-Cal dental providers. The Contractor will ensure referrals to dental providers.

6.7.3.6 VISION CARE - LENSES

The Contractor will order the fabrication of optical lenses for Members from Prison Industry Authority (PIA) optical laboratories. DHS will reimburse PIA for these lenses in accordance with the contract between DHS and PIA. The Contractor will provide all other Covered Services described in Title 22, CCR, Section 51317, including contact lenses and eyeglass frames.

6.7.3.7 DIRECT OBSERVED THERAPY (DOT) FOR TREATMENT OF TUBERCULOSIS

DOT services are not covered under this Contract. DOT services are offered by local health departments (LHDs). The Contractor will assess the risk of noncompliance for each Member who needs to be placed on anti-TB drugs. Members who are determined to be at risk will be referred to the LHD TB Control Officer for DOT. The Contractor will follow up and coordinate care with the LHD TB Control Officer.

The Contractor will refer the following groups of Members with active TB for DOT: patients with demonstrated multiple drug resistance (defined as resistance to Isoniazid and Rifampin), patients whose treatment has failed or who have relapsed after completing a prior regimen, children and adolescents, and individuals who have demonstrated noncompliance (those who failed to keep office appointments).

The Contractor will assess the following groups of Members for potential noncompliance and for consideration for DOT: substance abusers, persons with mental illness, the elderly, persons with unmet housing needs, and persons with language and/or cultural barriers.

6.7.3.8 DEPARTMENT OF DEVELOPMENTAL SERVICES ADMINISTERED MEDICAID HOME AND COMMUNITY BASED SERVICES WAIVER

The HCBS waiver services are not covered under this Contract. The Contractor will maintain systems for identifying developmentally disabled Members who are at risk

for institutional placement and refer these Members to the HCBS waiver administered by DDS. If DDS concurs with the Contractor's assessment of the Member and there is available placement in the waiver program, the Member will receive waiver services while enrolled in the plan. The Contractor will continue to provide all Primary Care and other Medically Necessary Covered Services to a plan Member who is receiving HCBS waiver services. If the Member does not meet the criteria for the waiver program, or if placement is not available, the Contractor will continue to case manage and provide all Medically Necessary Covered Services to the Member.

6.7.4 CAPITATED SERVICES: SERVICES WITH SPECIAL ARRANGEMENTS AND/OR PAYMENT OF OUT-OF-PLAN PROVIDERS

6.7.4.1 SCHOOL LINKED CHDP SERVICES: COORDINATION OF CARE

The Contractor will maintain a "medical home" for the Members and ensure the overall coordination of care and case management of Members who obtain CHDP services through the local school districts or school sites.

6.7.4.2 SCHOOL LINKED CHDP SERVICES: COOPERATIVE ARRANGEMENTS

The Contractor will enter into one or a combination of the following arrangements with the local school district or school sites:

A. Cooperative arrangements (e.g. Subcontracts) with school districts or school sites to directly reimburse schools for the provision of some or all of the CHDP services, including guidelines for sharing of critical medical information. The arrangements will also include guidelines specifying coordination of services, reporting requirements, quality standards, processes to ensure services are not duplicated, and processes for notification to Member/student/parent on where to receive initial and follow up services.

B. Cooperative arrangements whereby the Contractor agrees to provide or contribute staff or resources to support the provision of school linked CHDP services.

C. Referral protocols/guidelines between the Contractor and the school sites to assure that Members who are identified at school sites as being in need of CHDP services receive those services from the Contractor within the required State and federal time frames. This will include strategies for the Contractor to follow up and document that services

are provided to the Member.

D. Any innovative approach that the Contractor may develop to assure access to CHDP services and coordination with and support for school based health care services.

6.7.4.3 SCHOOL LINKED CHDP SERVICES: SUBCONTRACTS

The Contractor will ensure that the Subcontracts with the local school districts or school sites meet the requirements of Article III, Section 3.27 and address the following: the population covered, beginning and end dates of the agreement, services covered, practitioners covered, outreach, information dissemination and educational responsibilities, Utilization Review requirements, referral procedures, medical information flows, patient information confidentiality, Quality Assurance interface, data reporting requirements, Grievances and complaint procedures.

6.7.4.4 EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) SUPPLEMENTAL SERVICES, EXCLUDING CASE MANAGEMENT SERVICES

For members under the age of 21 years, the Contractor will provide or arrange and pay for EPSDT supplemental services as defined in Title 22, CCR, Section 51184, excluding EPSDT case management services, except when EPSDT supplemental services are provided as CCS services pursuant to Section 6.7.3.2. The Contractor will determine the medical necessity of EPSDT supplemental services using the criteria established in Title 22, CCR, Section 51340.

For Members under the age of 21 years, who meet the medical necessity criteria for EPSDT case management, pursuant to Title 22, CCR, Section 51340(f), the Contractor will refer the Member to a targeted case management (TCM) provider under contract with a local government agency pursuant to Welfare and Institutions Code Section 14132.44 or to entities and organizations, including Regional Centers, that provide TCM services pursuant to Welfare and Institutions Code Section 14132.48. If EPSDT case management services are rendered by these referral providers, the Contractor is not required to pay for the EPSDT case management services. If EPSDT case management services are not available from these referral providers, the Contractor will provide or arrange and pay for the EPSDT case management services.

6.7.4.5 FAMILY PLANNING: GENERAL REQUIREMENT

The Contractor will provide the full array of family planning services covered under the Contract without Prior Authorization. Medi-Cal Members have the right to access

family planning services through any family planning provider. The Contractor will inform its Members in writing of their right to access any qualified family planning provider without Prior Authorization as required in Section 6.9.5(P), Membership Services Guide.

6.7.4.6 FAMILY PLANNING: INFORMED CONSENT

The Contractor will ensure that informed consent will be obtained from Medi-Cal enrollees for all contraceptive methods, including sterilization, consistent with requirements of Title 22, CCR, Sections 51305.1 and 51305.3.

6.7.4.7 FAMILY PLANNING: OUT-OF-NETWORK REIMBURSEMENT

The Contractor will reimburse out-of-network family planning providers for the following services provided to Members of childbearing age to temporarily or permanently prevent or delay pregnancy:

A. Health education and counseling necessary to make informed choices and understand contraceptive methods.

B. Limited history and physical examination. Comprehensive physicals are the responsibility of the Contractor.

C. Laboratory tests if medically indicated as part of decision making process for choice of contraceptive methods. The Contractor will not be required to reimburse out-of-plan providers for pap smears if the Contractor has provided pap smears to meet the U.S. Preventive Services Task Force guidelines.

D. Diagnosis and treatment of STDs if medically indicated.

E. Screening testing and counseling of at risk individuals for HIV and referral for treatment.

F. Follow-up care for complications associated with contraceptive methods issued by the family planning provider.

G. Provision of contraceptive pills, devices, supplies.

H. Tubal ligation.

I. Vasectomies.

J. Pregnancy testing and counseling.

6.7.4.8 FAMILY PLANNING: REIMBURSEMENT RATE

The Contractor will reimburse out-of-plan family planning providers at the appropriate Medi-Cal FFS rate, unless otherwise negotiated.

6.7.4.9 SEXUALLY TRANSMITTED DISEASES (STDs)

The Contractor will provide access to STD services without Prior Authorization to all Members both within and outside its provider network. The reimbursement of out-of-plan STD services is limited to one office visit per disease episode for the purposes of: (1) diagnosis and treatment of vaginal discharge and urethral discharge, (2) those STDs that are amenable to immediate diagnosis and treatment, and this includes syphilis, gonorrhea, chlamydia, herpes simplex, chancroid, Trichomoniasis, human papilloma virus, non-gonococcal urethritis, lymphogranuloma venereum and granuloma inguinale and (3) evaluation and treatment of Pelvic Inflammatory Disease (PID). The Contractor will provide follow-up care. The Contractor will reimburse STD providers at the Medi-Cal Fee-For-Service (FFS) rate, unless otherwise negotiated, and the Contractor will provide reimbursement only if STD treatment providers provide treatment records or documentation of the Member's refusal to release Medical Records to the Contractor along with billing information.

6.7.4.10 EARLY INTERVENTION SERVICES

The Applicant will refer to the local Early Start program those children in need of early intervention services, e.g. those with an established condition leading to developmental delay, those in whom a significant development delay is suspected, or those whose early health history places them at risk for delay. The Contractor will also collaborate with the regional center or local Early Start program to provide all Medically Necessary diagnostic, preventive and treatment services.

6.7.4.11 SERVICES FOR PERSONS WITH DEVELOPMENTAL DISABILITIES

The Contractor will provide all screening, preventive, and Medically Necessary and therapeutic services covered by the Contract to Members with developmental disabilities. The Contractor will coordinate all medical services rendered to the Members, including the determination of medical necessity. The Contractor will refer enrollees with developmental disabilities to the regional centers for those nonmedical services such as respite, out-of-home placement, supportive living, etc. for persons with substantial disabilities if such services are needed.

6.7.4.12 CONFIDENTIAL HIV TESTING

Members may access confidential HIV counseling and testing services through the Contractor's provider network and through the out-of-network local health department and family planning providers. The Contractor will reimburse these providers at the Medi-Cal FFS rate, unless otherwise negotiated, for HIV testing and counseling provided that out-of-network local health departments and family planning providers make all reasonable efforts, consistent with current laws and regulations, to report confidential test results to the Contractor.

6.7.4.13 IMMUNIZATIONS

The Contractor will fully immunize its Members per DHS requirements. The Contractor will, upon request, provide updated information on the status of Members' immunizations and ensure reimbursement to LHDs for the administration fee of immunizations given to Members. However, the Contractor will not reimburse the LHD for an immunization provided to a Member who was already up to date as required per DHS. The LHD will provide immunization records when immunization services are billed to the Contractor. Providers other than LHDs will not be reimbursed by the Contractor unless they enter into an agreement with the Contractor.

6.7.4.14 NURSE MIDWIFE SERVICES

The Contractor will meet federal requirements for access and reimbursement for Nurse Midwife services as defined in Title 22, CCR, Section 51345. Federal guidelines are currently under development. If federal guidelines require that Members have a right to go out-of-plan for Nurse Midwife services, the Contractor will reimburse Nurse Midwives for services provided out-of-plan to the Contractor's Members at the Medi-Cal Fee-For-Service rate.

6.7.5 REQUIRED REFERRAL ARRANGEMENTS

6.7.5.1 WOMEN, INFANTS, AND CHILDREN (WIC) SUPPLEMENTAL FOOD PROGRAM: GENERAL REQUIREMENT

The Contractor, as part of its initial assessment of Members, and as part of the initial evaluation of newly pregnant women, will provide and document the referral of pregnant, breastfeeding, or postpartum women or a parent/guardian of a child under the age of five, as indicated, to the WIC program as mandated by Title 42, CFR 431.635(c).

6.7.5.2 WIC SUPPLEMENTAL FOOD PROGRAM: MEDICAL RECORDS

The Contractor will conduct the hemoglobin or hematocrit test and use the CHDP program Form PM160 to document the laboratory values for eligible children and/or a prescription pad written by a Physician to document laboratory values for eligible women for referral to the WIC program. The Contractor will document such referrals in the Members' Medical Records.

6.7.6 MEDICAL STANDARDS - CLINICAL PREVENTIVE SERVICES

6.7.6.1 INITIAL HEALTH ASSESSMENT

The Contractor will schedule and provide an initial health assessment (complete history and physical examination) to each Member within 120 days of the date of Enrollment, unless the Member's Primary Care Physician determines that the Member's Medical Record contains complete and current information consistent with the assessment requirements stated below. For Members age 21 years and older, the assessment will follow the guidelines required by Section 6.7.6.7. For Members under the age of 21 years, the assessment will follow the requirements of Title 17, CCR, Sections 6846 and 6847. If the Member fails to keep the scheduled appointment, the Contractor will recontact the Member in accordance with the procedures for follow up on missed appointments established pursuant to Section 6.5.10.5.

6.7.6.2 CHILDREN

The Contractor will maintain and operate a system which ensures the provision of CHDP services to Members under the age of 21 years in accordance with the provisions of the Health and Safety Code, Section 320 et seq. and Title 17, CCR, Section 6840 through 6850. The system will include the following components:

A. Initial health assessments as required by Section 6.7.6.1.

B. Notification, in writing, of the availability of health assessment services, the times and places where these services are available, and the method by which appointments for CHDP services may be made will be provided upon Enrollment and annually thereafter. Notification may be given to the parent(s) or guardian of the Member under the 21 years of age, or to the Member directly if the Member is an emancipated minor.

C. Where a request is made for CHDP services by the Member, the Member's parent(s) or guardian or through a referral from the local CHDP program, an appointment will be made for the Member to be examined within two weeks of the request.

D. Members under the age of 21 years will be scheduled for periodic health assessments in accordance with periodicity schedule recommended by the American Academy of Pediatrics and the immunizations will be provided following the recommendations of either the Advisory Committee on Immunization Practices or the American Academy of Pediatrics.

E. At each non-emergency Primary Care Encounter with Members under the age of 21 years, the Member (if an emancipated minor) or the parent(s) or guardian of the Member will be advised of the CHDP services available from Contractor, if the Member has not received CHDP services in accordance with the CHDP periodicity schedule. Documentation will be entered in the Member's Medical Record which will indicate the receipt of CHDP services in accordance with the CHDP periodicity schedule or proof of voluntary refusal of these services in the form of a signed statement by the Member (if an emancipated minor) or the parent(s) or guardian of the Member. If the responsible party refuses to sign this statement, the refusal will be noted in the Member's Medical Record.

F. Written notification and explanation of the results of CHDP health assessments will be supplied to the Member (if an emancipated minor) or the parent(s) or guardian of the Member in a timely manner. Upon request by the Member or the parent(s) or the guardian, the Contractor will provide for additional discussion or consultation regarding the results of the assessment if appropriate.

G. Diagnosis and treatment of any medical conditions identified through any CHDP assessment will normally be initiated within sixty days of the CHDP assessment appointment, consistent with the terms of the Contract for the identified services or conditions. Justification for delays beyond sixty days will be maintained in the Medical Record.

H. The Confidential Screening/Billing Report form, PM 160-PHP, will be used to report all CHDP Encounters. The Contractor will submit completed forms to DHS and to the local CHDP program within 30 days of the end of each month for all Encounters during that month.

I. The Contractor will coordinate its CHDP system with the Local CHDP program as required by Section 6.7.8.1.

6.7.6.3 PREGNANT WOMEN: MINIMUM STANDARDS

The Contractor will follow the American College of Obstetrics and Gynecologists (ACOG) standards (currently Seventh edition) as the minimum standards for services provided to Medi-Cal pregnant women. Contractor will develop and implement standardized risk assessment tools and risk intervention protocols which are consistent with CPSP requirements set forth in Title 22, CCR, Sections 51348 and 51348.1. Contractor will not implement them until they are approved by DHS.

6.7.6.4 PREGNANT WOMEN: PROVIDER CREDENTIALING STANDARDS

The Contractor will apply its provider Credentialing standards to all providers providing perinatal services. These Credentialing standards are specified in the Contractor's Quality Improvement document which must be approved by DHS. The Contractor's obstetrical providers are exempt from the requirement of certification as a Medi-Cal comprehensive perinatal services provider.

6.7.6.5 PREGNANT WOMEN: RISK ASSESSMENT

The Contractor will ensure that an obstetrical record and a comprehensive initial risk assessment tool is completed on all pregnant women at the initiation of pregnancy-related services. The risk assessment will include medical/obstetrical risk assessment; nutritional assessment; psychosocial assessment; and health education assessment. Evaluation of the patient's risk status will be done at each trimester and at the postpartum visit. All identified risk conditions will be followed up by interventions designed to ameliorate or remedy the condition or problem in a prioritized manner.

6.7.6.6 PREGNANT WOMEN: REFERRALS TO SPECIALISTS

The Contractor will implement and maintain policies and procedures for appropriate referrals of high risk pregnancy women to specialists and have procedures for genetic screening and referral, and for admission to the appropriate hospitals for delivery.

6.7.6.7 ADULTS

Contractor will implement and maintain The Guide to Clinical Preventive Services, a report of the U.S. Preventive Service Task Force (USPSTF) as the minimum acceptable standard for Adult Preventive Health Services. The following are a core set of preventive services that will be provided to all asymptomatic, healthy adult Members (age 21 and older): (This is not an inclusive list of all appropriate preventive services. The presence of risk factors in individual patients will affect the type and quantity of preventive services that may be appropriate. A given patient may need additional services or core services at more frequent intervals).

A. History and physical examination - an initial complete history and physical examination will be performed on each adult Member within 120 days of Enrollment. Targeted history and physical examination focusing on the needs and risk factors of each Member will be done every one to three years for adults age 21 to 64 years; and annually for individuals age 65 and older.

B. Blood pressure - persons who are normotensive will have blood pressure measurements at least every 2 years.

C. Cholesterol - total cholesterol will be measured at least once every 5 years for adults age 20 and older.

D. Clinical breast examination - women over age 40 will have annual clinical breast examination.

E. Mammogram - all women over age 50 will have a screening mammogram every 1 to 2 years, concluding at age 75 unless pathology has been demonstrated.

F. Pap Smear - beginning at the age of first sexual intercourse, pap smears will be performed every one to three years, depending on the presence or absence of risk factors.

G. Tuberculosis (Tb) screening - all adults will be screened for Tb risk factors upon Enrollment and Mantoux skin test will be performed on all persons at increased risk of developing Tb.

6.7.6.8 TUBERCULOSIS (Tb)

Tb screening, diagnosis, treatment and follow-up are covered under the Contract. The Contractor will provide Tb care and treatment in compliance with the guidelines recommended by American Thoracic Society and the Centers for Disease Control. Following the award, but prior to beginning operation, DHS will evaluate the Contractor's capability to deliver Tb care. If the Contractor is not capable of providing adequate Tb care, it will subcontract for those services. The Contractor will coordinate with LHDs in the provision of DOT, contact tracing, and other Tb services.

6.7.7 HEALTH EDUCATION

6.7.7.1 GENERAL REQUIREMENTS

The Contractor will implement and maintain a system for providing Member health education services, clinical preventive services, health education and promotion and patient education and counseling. The system will utilize one to one and group interventions, written and audio-visual materials. The Contractor will ensure that the services are provided directly by the Contractor or through Subcontracts or formal agreements with other providers specializing in health education services. The Contractor will maintain a health education system which includes, at a minimum, the following services:

A. Member Education

1. Use of Clinical Preventive Services.

2. Promote Appropriate Use of Managed Care Plan Services.

3. Availability of Local Social and Health Care Programs.

B. Clinical Preventive Services, Education and Counseling:

1. Nutrition

2. Tobacco Prevention and Cessation

3. HIV/STD Prevention

4. Family Planning

5. Exercise

6. Dental

7. Perinatal

8. Age Specific Anticipatory Guidance - EPSDT

9. Injury Prevention

10. Immunizations

C. Patient Education and Clinical Counseling

1. Diabetes

2. Asthma

3. Hypertension

4. Substance Abuse

5. Tuberculosis

6. Inpatient - Condition Specific

7. Other Outpatient

6.7.7.2 HEALTH EDUCATOR

The Contractor will maintain administrative oversight of the program by a qualified full time health educator with a masters degree in community or public health education (MPH).

6.7.7.3 BEHAVIORAL ASSESSMENTS

The Contractor will ensure that individual health education behavioral assessments are conducted on all Members within 120 days of Enrollment to determine health practices, values, behaviors, knowledge, attitudes, cultural practices, beliefs, literacy levels, or health education needs.

6.7.7.4 HEALTH EDUCATION POLICIES AND PROCEDURES

The Contractor will develop, implement, and maintain standards, policies and procedures and ensure provision of the following:

A. Member orientation, education regarding health promotion, personal health behavior, and patient education and counseling.

B. Provider education on health education services.

C. Individual health education behavioral assessment, referral, and follow-up.

6.7.7.5 HEALTH EDUCATION STANDARDS

The Contractor will develop and maintain health education services standards, policies and procedures, and monitor provider performance to ensure the standards for health education services are maintained and include methods for formally communicating findings with providers.

6.7.7.6 HEALTH EDUCATION AND QIP

The Contractor will ensure coordination and integration of the health education system with the Quality Improvement program.

6.7.7.7 GROUP NEEDS ASSESSMENT

The Contractor will conduct a group needs assessment of their Members to determine health education needs including literacy level. The Contractor will submit to DHS a report summarizing the methodology, findings, proposed services, key activities, timeline for implementation and the responsible individuals. The Contractor will complete the needs assessment within six months after one year of operations under this Contract.

6.7.7.8 HEALTH EDUCATION WORKPLAN

If the Contractor does not comply with all of the requirements in Sections 6.7.7.1 through 6.7.7.9 upon implementation of die Contract, the Contractor will comply with all of the requirements for the provision of health education services except for the requirements in Section 6.7.7.6. Contractor will submit for DHS' approval a proposed workplan for meeting the full scope of requirements by the end of one year of operations under this Contract. Contractor will include in the workplan a description of the required activities, a timeline with milestones, and identify the

responsible individuals and the individual with overall responsibility. The Contractor will entitle the workplan "Health Education Services: Proposed Activities".

6.7.7.9 HEALTH EDUCATION READING LEVEL

The Contractor will ensure that all plan materials used to communicate covered benefits are written at the appropriate reading level, as determined by the Contractor and approved by DHS.

6.7.8 LOCAL HEALTH DEPARTMENT COORDINATION

6.7.8.1 SUBCONTRACT

The Contractor will execute a Subcontract for the specified public health services with the Local Health Department (LHD) in each county that is covered by this Contract. The Subcontract will specify the scope and responsibilities of both parties, billing and reimbursements, reporting responsibilities, and Medical Record management to ensure coordinated health care services. The Subcontract will meet the requirements contained in Article III, Sections 3.27 through 3.27.8. The specified public health services under the Subcontract are as follows:

A. Family Planning Services: as specified in Section 6.7.4.7

B. STD services diagnosis and treatment of disease episode of the following STDs: syphilis, gonorrhea, chlamydia, herpes simplex, chancroid, trichomoniasis, human papilloma virus, non-gonococcal urethritis, lymphogranuloma venereum and granuloma inguinale.

C. Confidential HIV testing: as specified in Section 6.7.4.12

D. Immunizations: as specified in Section 6.7.4.13

E. California Children Services (CCS)

F. Maternal and Child Health (MCH)

G. Child Health and Disability Prevention (CHDP) Program

H. Tuberculosis Direct Observed Therapy

I. Women, Infants, and Children (WIC) Supplemental Food Program

J. Population based Prevention Programs: collaborate in LHD community based prevention programs

Services A-D require provisions for reimbursement. All services require delineation of the roles and responsibilities of the Contractor and the local program.

To the extent that Contractor does not meet this requirement on or before 4 months after award of this Contract, Contractor will submit documentation substantiating reasonable efforts to enter into Subcontracts.

6.8 MARKETING AND ENROLLMENT

6.8.1 MARKETING REPRESENTATIVES

The Contractor will ensure, in addition to compliance with the requirements of Title 22, CCR, Section 53400, that:

A. All Marketing Representatives including supervisors, have satisfactorily completed the Contractor's Marketing orientation and training program and the DHS Marketing Representative Certification Examination prior to engaging in Marketing activities on behalf of the Contractor.

B. A Marketing Representative will not provide Marketing services on behalf of more than one Contractor.

C. Marketing Representatives do not engage in Marketing practices that discriminate against an Eligible Beneficiary because of race, creed, age, color, sex, religion, national origin, ancestry, marital status, sexual orientation, physical or mental handicap, or health status.

6.8.2 LIABILITY

The Contractor is responsible for all Marketing activity conducted on behalf of the Contractor. Contractor will be held liable for any and all violations by any Marketing Representatives.

6.8.3 CERTIFICATION OF MARKETING REPRESENTATIVES

The Contractor will ensure that any office staff of a provider whose primary duties are Marketing, are certified as Marketing Representatives.

6.8.4 ENROLLMENT PROGRAM

Contractor will cooperate and participate in the DHS Enrollment program and will provide to DHS' Enrollment contractor Marketing materials, Evidence of Coverage and disclosure forms, Member services guide, list of network providers, linguistic and cultural capabilities of the Contractor and other information deemed necessary by DHS to assist beneficiaries in making an informed choice of health plan.

6.8.5 DISENROLLMENT FORMS

Contractor will ensure that Disenrollment forms are available at all Primary Care sites and that staff at those locations are knowledgeable of Enrollment and Disenrollment requirements.

6.8.6 MARKETING PLAN

Except for door to door Marketing which is prohibited, Contractors will implement and maintain a Marketing plan in compliance with MCOB Letter 93-12.

6.8.7 DHS APPROVAL

Contractor will not conduct Marketing activities without written approval of its Marketing plan from DHS.

6.9 MEMBER SERVICES/GRIEVANCE SYSTEM

6.9.1 SYSTEM CAPACITY

Contractor will maintain the capability to provide Member services to Medi-Cal Members through sufficient assigned staff.

6.9.2 MEMBER SERVICES EMPLOYEE TRAINING

Contractor will ensure membership services staff are trained on all contractually required membership service functions including, policies, procedures, and scope of benefits.

6.9.3 DISCLOSURE FORMS

Contractor will provide to all Members Disclosure Forms and Evidence of Coverage materials which constitute a fair disclosure of the provisions of the covered health care services.

6.9.4 MEMBER IDENTIFICATION CARD

Contractor will provide an identification card to each Member which identifies the Member and authorizes the provision of Covered Services to the Member. The card will specify that Emergency Services rendered to the Member by non-Contracting providers are reimbursable by the Contractor without Prior Authorization.

6.9.5 MEMBERSHIP SERVICES GUIDE

Contractor will develop and distribute a Membership Services Guide that includes the following information:

A. The name, address and telephone number of the health plan.

B. A description of the full scope of Medi-Cal covered benefits and all available services including health education, interpretive services, and "carve out" services and an explanation of any service limitations and exclusions from coverage.

C. Procedures for obtaining Covered Services including the address and telephone number of each Service Site (locations of hospitals, Primary Care Physicians, optometrists, psychologists, pharmacies, Skilled Nursing Facilities, Urgent Care Facilities). In the case of a medical foundation or independent practice association, the address and telephone number of each Physician provider.

   1. The hours and days when each of these Facilities is open, the services and benefits available, and the telephone number to call after normal business hours.

D. Procedures for selecting or requesting a change in Primary Care Physician, including requirements for change in PCP; reasons for which a request may be denied; and reasons why a provider may request a change.

E. The purpose and value of scheduling an initial health assessment appointment.

F. The appropriate use of health care services in a managed care system.

G. The availability and procedures for obtaining after hours services (24-hour basis) and care, including the appropriate provider locations and telephone numbers.

H. Procedure for obtaining emergency health care both within and outside the Contractor's Service Area.

I. Process for referral to specialists.

J. Procedures for obtaining transportation services if offered by the Contractor.

K. The causes for which a Member will lose entitlement to receive services under this Contract. (See Article III, Section 3.27.5)

L. Procedures for filing a complaint/Grievance, including procedures for appealing decisions regarding Member's coverage, benefits, or relationship to the organization. Include the title, address, and telephone number of the person responsible for processing and resolving complaints/Grievances.

M. Procedures for Disenrollment, including an explanation of the Member's right to disenroll without cause at any time.

N. Information on the Member's right to the Medi-Cal fair hearing process regardless of whether or not a complaint/Grievance has been submitted or if the complaint/Grievance has been resolved. The State Department of Social Services' Public Inquiry and Response Unit toll free telephone number (800) 952-5253.

O. Information on the availability of, and procedures for obtaining, services at FQHCs and Indian Health Clinics.

P. Information on the Member's right to seek family planning services from any qualified provider of family planning services such as the following statement:

"Family planning services are provided to Members of child bearing age to enable them to determine the number and spacing of children. These services include all methods of birth control approved by the Federal Food and Drug Administration. As a Member, you pick a doctor who is located near you and will give you the services you need. Our Primary Care Physicians and OB/GYN specialists are available for family planning services. For family planning services, you may also pick a doctor or clinic not connected with Molina Medical Centers without having to get permission from Molina Medical Centers. Molina Medical Centers will pay that doctor or clinic for the family planning services you get".

Q. DHS' Office of Family Planning's toll free telephone number (1-800-942-1054) providing consultation and referral to family planning clinics.

R. Any other information determined by DHS to be essential for the proper receipt of Covered Services.

6.9.6 ENROLLEE INFORMATION

The Contractor will provide the following information to the Member or Member's family unit either in the form of a cover letter or insert in the above prescribed Membership Services Guide:

A. Each Member's effective date of Enrollment and term of Enrollment.

B. The name, telephone number, and Service Site address of the Primary Care Physician chosen by or assigned to the Member.

6.9.7 DISTRIBUTION OF MEMBER SERVICES INFORMATION

The Contractor will distribute the Member identification card and membership services guide to all Members, including family members, no later than seven (7) days after the effective date of the Member's Enrollment. The Contractor will revise this information, if necessary, and distribute it annually to each Member or Member's family unit.

6.9.8 CHANGES IN AVAILABILITY OR LOCATION OF COVERED SERVICES

Contractor will ensure Medi-Cal Members are notified in writing of any changes in the availability or location of Covered Services at least thirty (30) days prior to the effective date of such changes, or within fourteen (14) days prior to the change in cases of unforeseeable circumstances. The notification must be approved by DHS prior to the release.

6.9.9 PRIMARY CARE PHYSICIAN SELECTION

The Contractor will implement and maintain DHS approved procedures to ensure that each Member is allowed to select or change a Primary Care Physician from the Contractor's network of providers. The Contractor will assist Members in making their selection within thirty (30) days of their effective date of Enrollment. The Contractor will provide the Member sufficient information (verbal and written) in the appropriate language and reading level about the selection process and the available

providers in the network to ensure their ability to make an informed decision.

6.9.10 PRIMARY CARE PHYSICIAN ASSIGNMENT

If the Member does not select a Primary Care Physician within thirty (30) days of the effective date of Enrollment, Contractor will complete the assignment of the Member to a Primary Care Provider, notify the Member and the assigned Primary Care Physician within forty (40) days from the effective date of Enrollment. Contractor will ensure that adverse selection does not occur during the assignment process of Members to providers.

6.9.11 CONTINUITY OF CARE

The Contractor will ensure that Members with an established relationship with a provider in the network, who have expressed a desire to continue their patient/provider relationship, are assigned to their provider without disruption in their care.

6.9.12 DISCLOSURE

The Contractor will disclose to affected Members any reasons for which their selection or change in Primary Care Physician could not be made.

6.9.13 MEMBER COMPLAINT/GRIEVANCE SYSTEM

Contractor will implement and maintain a Member complaint/Grievance system in accordance with Title 10, CCR, Section 1300.68, except subsection 1300.68(g), and Title 22, CCR, Sections 53200 and 53260.

A. Contractor will acknowledge receipt of a complaint within 5 days. The written acknowledgement will also notify the complainant of a person at the plan who may be contacted regarding the complaint. The Contractor will resolve the complaint within 30 days.

6.9.14 DISENROLLMENTS

Contractor will implement and maintain procedures to ensure that requests for Disenrollments made under the following circumstances are referred to the county Enrollment Contractor immediately and are not processed through the Grievance process:

A. The Member's eligibility as a Medi-Cal beneficiary for Enrollment in the plan is terminated.

B. The Enrollment is in violation of Sections 53400 or 53402.

C. The request for Disenrollment is pursuant to Section 53508.

D. Change of a Member's place of residence outside the plan's Service Area.

6.9.15 DENIAL, DEFERRAL, OR MODIFICATION OF PRIOR AUTHORIZATION REQUESTS

A. Contractor will notify Members of denial, deferral, or modification of requests for Prior Authorization, in accordance with Title 22, CCR, Sections 51014.1 and 53261 by providing written notification to Members and/or their authorized representative, regarding any denial, deferral or modification of a request for approval to provide a health care service. This notification must be provided as specified in Title 22, CCR, Sections 51014.1 and 53261, when all of the following conditions exists:

1. The request is made by a health care provider who has a formal arrangement with the Contractor to provide services to Medi-Cal Members.

2. The request is made by the provider through the formal Prior Authorization procedures operated by the Contractor.

3. The service for which Prior Authorization is requested is a Medi-Cal Covered Service for which the Contractor has established a Prior Authorization requirement.

4. The Prior Authorization decision is being made at the ultimate level of responsibility within the Contractor's organization for approving, denying, deferring or modifying the service requested but prior to the point at which the Member must initiate the Contractor's complaint/Grievance procedure.

B. Contractor will provide for a written notification to the Member and the Member's representative on a standardized form approved by DHS, informing the Member of all the following:

1. The Member's right to, and method of obtaining, a fair hearing to contest the denial, deferral or modification action.

2. The Member's right to represent himself/herself at the fair hearing or to be represented by legal counsel, friend or other spokesperson.

3. The name and address of the Contractor and the State toll-free telephone number for obtaining information on legal service organizations for representation.

C. The notice to the Member may inform the Member that the Member may file a complaint/Grievance concerning the Contractor's action using the Contractor's complaint/Grievance process prior to or concurrent with the initiation of the fair hearing process.

D. The Contractor will provide required notification to beneficiaries and the representatives in accordance with the time frames set forth in Title 22, CCR, Sections 51014.1 and 53261.

6.10 CULTURAL AND LINGUISTIC SERVICES REQUIREMENTS

6.10.1 CIVIL RIGHTS ACT OF 1964

The Contractor will ensure compliance with Title 6 of the Civil Rights Act of 1964 (42 U.S.C. Section 2000d, 45 C.F.R. Part 80) which prohibits recipients of federal financial assistance from discriminating against persons based on race, color, or national origin.

The Contractor will provide 24 hour access to interpreter services for all Members at all provider sites within the Contractor's network either through telephone language services or interpreters.

6.10.2 LINGUISTIC SERVICES

The Contractor will provide linguistic services to a population group of mandatory Medi-Cal eligibles residing in the proposed Service Area who indicate their primary language as other than English and who meet a numeric threshold of 3,000, or a population group of mandatory Medi-Cal eligibles residing in the proposed Service Area who indicate their primary language as other than English and who meet the concentration standards of 1,000 in a single ZIP code or 1,500 in two contiguous ZIP codes.

The Contractor will provide the following services to those Member groups at these key points of contact:

A. Key Points of Contact

1. Medical: Advice and Urgent Care telephone, face to face Encounters with providers.

2. Non-medical: membership services, orientations, and appointments.

B. Types of Services

1. Interpreters.

2. Translated signage.

3. Translated written materials.

4. Referrals to culturally and linguistically appropriate community services programs.

6.10.3 LINGUISTIC CAPABILITY OF EMPLOYEES

The Contractor will assess, identify and report the linguistic capability of interpreters or bilingual employed and contracted staff (clinical and non-clinical).

6.10.4 SUBCONTRACTS

The Contractor will document in the Subcontracts with Traditional and Safety-Net providers the linguistic services to be provided and the individuals who will provide the linguistic services to Members within the proposed Service Area.

6.10.5 COMMUNITY ADVISORY COMMITTEE

Contractor will implement and maintain community linkages through the formation of a Community Advisory Committee (CAC) with demonstrated participation of consumers, community advocates, and Traditional and Safety-Net providers. The Contractor will ensure that the committee responsibilities include advisement on educational and operational issues affecting groups who speak a primary language other than English and cultural competency.

6.10.6 CULTURAL AND LINGUISTIC SERVICES PLAN

Contractor will ensure that a group needs assessment is conducted to identify the linguistic and cultural needs of the groups who speak a primary language other than English. The findings of the assessment will be submitted to DHS in the form of a plan entitled "Cultural and Linguistic Services Plan" at the end of the first year of operations. In the plan, the Contractor will summarize the methodology, findings, and outline the proposed services to be implemented, the timeline for implementation with milestones, and the responsible individual. The Contractor will ensure implementation of the Cultural and Linguistic Services Plan within six months after the beginning of year two of operations. The Contractor will also identify the individual with overall responsibility for the activities to be conducted under the plan. DHS approval of the plan is required prior to its implementation.

6.10.7 IMPLEMENTATION PLAN

If a Contractor does not comply with all of the Cultural and Linguistic Services requirements in Sections 6.10 through 6.10.9 upon implementation of the Contract, the Contractor will comply with the threshold requirements in Sections 6.10.1, 6.10.2, 6.10.2-A through 6.10.2-B(1), 6.10.2-B(4), 6.10.4 and 6.10.7 for the provision of oral interpretation services to the groups who speak a primary language other than English meeting the thresholds.

The Contractor will submit for DHS approval a proposed workplan for meeting the full scope of requirements. In the workplan, the Contractor will include a description of the required activities, a timeline with milestones, and identify the individuals responsible for the activity. The Contractor will identify the individual with overall responsibility and ensure that the activities identified in the workplan approved by DHS will be fully operational within six months of the beginning of year two of operations under the Contract. The Contractor will entitle the workplan "Cultural and Linguistic Services: Proposed Activities".

6.10.8 STANDARDS AND PERFORMANCE REQUIREMENTS

Contractor will develop and implement standards and performance requirements for the provision of linguistic services, and will monitor the performance of the individuals who provide linguistic services.

6.10.9 INTERPRETER COORDINATION

Contractor will develop and implement standards for appointment scheduling and a system for coordinating interpreters, to ensure continuity in the assignment of interpreters to Members when follow-up care is required.

6.11 IMPLEMENTATION PLANS

6.11.1 TIME FRAMES

The Contractor will submit deliverables within the timeframes specified on the Implementation Plan approved by DHS. Compliance with the schedule is mandatory unless otherwise approved by DHS. (See Article III, Section 3.19, Liquidated Damages Provisions). Unless otherwise specified, all completion dates listed for the deliverables are calculated from the Contract effective date.

6.11.2 IMPLEMENTATION PLAN OVERSIGHT

The Contractor will identify a single individual to be responsible for oversight of the Implementation Plan.

6.11.3 MONTHLY PROGRESS REPORTS

The Contractor will submit monthly written progress reports to DHS at the request of DHS.

The progress reports will contain the following:

A. Any discrepancies with the Implementation Plan.

B. Activity number and name the Contractor assigns to each deliverable/milestone.

C. Description of current activities that have taken place toward achieving the deliverable/milestone.

D. Summary of activities yet to be accomplished toward completion of the deliverable/milestone.

E. Due date in the Implementation Plan.

F. Current estimated due date.

G. If the estimated due date in later than the Implementation Plan due date, then:

1. Identify reasons why the activity is not on schedule, and

2. Identify actions the Contractor is taking to remedy the activity and meet the due date.

Molina Medical Centers

Attachment I
95-23637

Plan Name: Mainstream
Plan Number:
County: San Bernardino
Aid Code: Family

Base Period: CY '93
Rate Period: 7/95 - 5/96
Capitation Payable: End of Month

	Phys	Pharm	HIP	HOP	LTC	Other	Total
Units per 1,000 eligibles	3.816	4.223	.370	2.232	.000	3.330	
Age/sex Adjustment	1.026	.997	1.040	1.019	1.000	1.010	
Aid Code Adjustment	.989	.990	.985	.995	1.000	.976	
Adjusted Units	3.872	4.168	.379	2.263	.000	3.283	
Average Cost Per Unit	71.93	14.73	880.94	21.79	369.03	28.02	
Area Adjustment	1.013	1.000	1.000	1.000	1.000	1.000	
Adjusted Cost	$ 72.87	$ 14.73	$ 880.94	$ 21.79	$ 369.03	$ 28.02	
Interest Adjustment	.997	1.000	.994	.997	.997	.997	
Contract Cost per Eligible	$ 281.31	$ 61.39	$ 331.87	$ 49.16	$ .00	$ 91.71	$ 815.44
Benefit Adjustments							
FY 94/95	1.003	.852	1.030	1.003	1.042	1.013	
FY 95/96	1.000	.724	1.018	1.000	1.020	.975	
Trend Adjustment 7/93 - 1/96	1.027	1.220	1.043	.945	1.000	1.317	*
Annual Cost Per Eligible	$ 289.77	$ 46.20	$ 362.94	$ 46.60	$ .00	$ 119.42	$ 864.93
Mental Health Adjustment	1.4%	.0%	6.6%	5.0%	1.5%	4.5%	
Eyewear Adjustment						1.5%	
Cost Excluding Mental Health	$ 285.71	$ 46.20	$ 338.99	$ 44.27	$ .00	$ 112.34	$ 827.51
Preliminary Monthly Rate							$ 68.96
Adj. for Fee-for-Service Limitation		-2.0%					$ -1.38
CHDP							2.43
Final Rate							$ 70.01

Attachment I

Plan Name: Mainstream
Plan Number:
County: San Bernardino
Aid Code: Child

Base Period: CY '93
Rate Period: 7/95 - 5/96

Capitation Payable: End of Month

	Phys	Pharm	HIP	HOP	LTC	Other	Total
Units per 1,000 eligibles	3.791	3.907	.361	1.620	.000	1.882	
Age/sex Adjustment	1.184	1.019	1.227	1.087	1.000	1.109	
Aid Code Adjustment	1.011	.993	1.025	1.010	1.000	.998	
Adjusted Units	4.538	3.953	.454	1.779	.000	2.083	
Average Cost Per Unit	69.47	11.05	901.25	22.20	.00	40.13	
Area Adjustment	1.013	1.000	1.000	1.000	1.000	1.000	
Adjusted Cost	$ 70.37	$ 11.05	$ 901.25	$ 22.20	$ .00	$ 40.13	
Interest Adjustment	.996	.999	.990	.994	.998	.995	
Contract Cost per Eligible	$ 318.06	$ 43.64	$ 405.08	$ 39.26	$ .00	$ 83.17	$ 889.21
Benefit Adjustments							
FY 94/95	1.003	.852	1.031	1.003	1.042	1.001	
FY 95/96	1.000	.724	1.018	1.000	1.020	.976	
Trend Adjustment 7/93 - 1/96	1.040	1.238	.853	.906	1.000	1.210	
Annual Cost Per Eligible	$ 331.77	$ 33.33	$ 362.66	$ 35.68	$ .00	$ 98.32	$ 861.76
Mental Health Adjustment	1.6%	.0%	13.4%	2.9%	3.4%	3.6%	
Eyewear Adjustment						.9%	
Cost Excluding Mental Health	$ 326.46	$ 33.33	$ 314.06	$ 34.65	$ .00	$ 93.93	$ 802.43
Preliminary Monthly Rate							$ 66.87
Adj. for Fee-for-Service Limitation		-2.0%					$ -1.34
CHDP							2.38
Final Rate							$ 67.91

Attachment I

Plan Name: Mainstream
Plan Number:
County: San Bernardino
Aid Code: Aged

Base Period: CY '93
Rate Period: 7/95 - 5/96

Capitation Payable: End of Month

	Phys	Pharm	HIP	HOP	LTC	Other	Total
Units per 1,000 eligibles	4.280	19.624	1.476	1.310	2.880	14.314	
Age/sex Adjustment	.986	1.004	.995	.987	1.031	1.005	
Aid Code Adjustment	.936	1.021	.968	.931	1.007	1.016	
Adjusted Units	3.950	20.116	1.422	1.204	2.990	14.616	
Average Cost Per Unit	44.28	28.65	265.64	16.35	76.99	6.95	
Area Adjustment	1.013	1.000	1.000	1.000	1.000	1.000	
Adjusted Cost	$ 44.86	$ 28.65	$ 265.64	$ 16.35	$ 76.99	$ 6.95	
Interest Adjustment	.994	1.000	.990	.991	.998	.996	
Contract Cost per Eligible	$ 176.13	$ 576.32	$ 373.96	$ 19.51	$ 229.74	$ 101.17	$ 1,476.83
Benefit Adjustments							
FY 94/95	1.003	.852	1.036	1.003	1.042	1.001	
FY 95/96	1.000	.724	1.018	1.000	1.020	1.000	
Trend Adjustment 7/93 - 1/96	1.347	1.194	.925	1.091	1.054	1.404	
Annual Cost Per Eligible	$ 237.96	$ 424.47	$ 364.82	$ 21.35	$ 257.36	$ 142.18	$ 1,448.14
Mental Health Adjustment	.3%	.0%	.7%	.9%	.4%	.0%	
Eyewear Adjustment						2.1%	
Cost Excluding Mental Health	$ 237.25	$ 424.47	$ 362.27	$ 21.16	$ 256.33	$ 139.19	$ 1,440.67
Preliminary Monthly Rate							$ 120.06
Adj. for Fee-for-Service Limitation		-2.0%					$ -2.40
CHDP							.00
Final Rate							$ 117.66

Attachment I

Plan Name: Mainstream
Plan Number:
County: San Bernardino
Aid Code: Disabled

Base Period: CY '93
Rate Period: 7/95 - 5/96

Capitation Payable: End of Month

	Phys	Pharm	HIP	HOP	LTC	Other	Total
Units per 1,000 eligibles	7.452	23.494	1.498	4.212	1.440	28.577	
Age/sex Adjustment	1.005	.979	.990	1.001	1.011	1.008	
Aid Code Adjustment	.994	1.003	.983	.993	.999	1.004	
Adjusted Units	7.444	23.070	1.458	4.229	1.454	28.921	
Average Cost Per Unit	43.31	32.19	511.29	18.05	108.27	10.65	
Area Adjustment	1.013	1.000	1.000	1.000	1.000	1.000	
Adjusted Cost	$ 43.87	$ 32.19	$ 511.29	$ 18.05	$ 108.27	$ 10.65	
Interest Adjustment	.995	.999	.991	.993	.999	.996	
Contract Cost per Eligible	$ 324.94	$ 741.88	$ 738.75	$ 75.80	$ 157.27	$ 306.78	$ 2,345.42
Benefit Adjustments							
FY 94/95	1.003	.852	1.036	1.003	1.042	1.001	
FY 95/96	1.000	.724	1.018	1.000	1.020	1.000	
Trend Adjustment 7/93 - 1/96	1.115	1.190	.986	1.047	.992	1.233	
Annual Cost Per Eligible	$ 363.40	$ 544.58	$ 768.21	$ 79.60	$ 165.82	$ 378.64	$ 2,300.25
Mental Health Adjustment	7.8%	.0%	11.7%	2.4%	1.3%	1.4%	
Eyewear Adjustment						.9%	
Cost Excluding Mental Health	$ 335.05	$ 544.58	$ 678.33	$ 77.69	$ 163.66	$ 369.98	$ 2,169.29
Preliminary Monthly Rate							$ 180.77
Adj. for Fee-for-Service Limitation		-2.0%					$ -3.62
CHDP							.00
Final Rate							$ 177.15

Attachment I

Plan Name: Mainstream
Plan Number:
County: San Bernardino
Aid Code: Adult

Base Period: CY '93
Rate Period: 7/95 - 5/96

Capitation Payable: End of Month

	Phys	Pharm	HIP	HOP	LTC	Other	Total
Units per 1,000 eligibles	22.752	5.069	3.590	4.465	.000	20.412	
Age/sex Adjustment	1.000	1.000	1.000	1.000	1.000	1.000	
Aid Code Adjustment	1.000	1.000	1.000	1.000	1.000	1.000	
Adjusted Units	22.752	5.069	3.590	4.465	.000	20.412	
Average Cost Per Unit	59.80	16.00	960.30	20.51	.00	43.66	
Area Adjustment	1.013	1.000	1.000	1.000	1.000	1.000	
Adjusted Cost	$ 60.58	$ 16.00	$ 960.30	$ 20.51	$ .00	$ 43.66	
Interest Adjustment	.996	.999	.995	.993	.996	.995	
Contract Cost per Eligible	$ 1,372.80	$ 81.02	$ 3,430.24	$ 90.94	$ .00	$ 886.73	$ 5,861.73
Benefit Adjustments							
FY 94/95	1.003	.852	1.035	1.003	1.042	1.013	
FY 95/96	1.000	.724	1.018	1.000	1.020	1.000	
Trend Adjustment 7/93 - 1/96	1.076	1.020	1.086	1.122	1.000	1.139	
Annual Cost Per Eligible	$ 1,481.56	$ 50.98	$ 3,925.30	$ 102.34	$ .00	$ 1,023.12	$ 6,583.03
Mental Health Adjustment	.1%	.0%	.3%	1.1%	.0%	.1%	
Eyewear Adjustment						.4%	
Cost Excluding Mental Health	$ 1,480.08	$ 50.98	$ 3,913.25	$ 101.21	$ .00	$ 1,018.01	$ 6,563.53
Preliminary Monthly Rate							$ 546.96
Adj. for Fee-for-Service Limitation		-2.0%					$ -10.94
CHDP							.00
Final Rate							$ 536.02

Attachment I

Plan Name: Mainstream
Plan Number:
County: San Bernardino

Base Period: CY '93
Rate Period: 6/96 - 9/97

Capitation Payable: End of Month

Aid Code: Family

	Phys	Pharm	HIP	HOP	LTC	Other	Total
Units per 1,000 eligibles	3.816	4.223	.370	2.232	.000	3.330	
Age/sex Adjustment	1.026	.997	1.040	1.019	1.000	1.010	
Aid Code Adjustment	.989	.990	.985	.995	1.000	.976	
Adjusted Units	3.872	4.168	.379	2.263	.000	3.283	
Average Cost Per Unit	71.93	14.73	880.94	21.79	369.03	28.02	
Area Adjustment	1.013	1.000	1.000	1.000	1.000	1.000	
Adjusted Cost	$ 72.87	$ 14.73	$ 800.94	$ 21.79	$ 369.03	$ 28.02	
Interest Adjustment	.997	1.000	.994	.997	.997	.997	
Contract Cost per Eligible	$ 281.31	$ 61.39	$ 331.87	$ 49.16	$ .00	$ 91.71	$ 815.44
Benefit Adjustments							
FY 94/95	1.003	.852	1.030	1.003	1.042	1.013	
FY 95/96	1.000	.724	1.018	1.000	1.020	.976	
Trend Adjustment 7/93 - 1/97	1.036	1.313	1.060	.925	1.000	1.454	
Annual Cost Per Eligible	$ 292.31	$ 49.72	$ 368.86	$ 45.61	$ .00	$ 131.84	$ 888.34
Mental Health Adjustment	1.4%	6.0%	6.6%	5.0%	l.5%	4.5%	
Eyewear Adjustment						1.5%	
Cost Excluding Mental Health	$ 288.22	$ 46.74	$ 344.52	$ 43.33	$ .00	$ 124.02	$ 846.83
Preliminary Monthly Rate							$ 70.57
Adj. for Fee-for-Service Limitation		-2.0%					$ -1.41
CHDP							2.43
Final Rate							$ 71.59

Attachment I

Plan Name: Mainstream
Plan Number:
County: San Bernardino
Aid Code: Child

Base Period: CY '93
Rate Period: 6/96 - 9/97
Capitation Payable: End of Month

	Phys	Pharm	HIP	HOP	LTC	Other	Total
Units per 1,000 eligibles	3.791	3.907	.361	1.620	.000	1.882	
Age/sex Adjustment	1.184	1.019	1.227	1.087	1.000	1.109	
Aid Code Adjustment	1.011	.993	1.025	1.010	1.000	.998	
Adjusted Units	4.538	3.953	.454	1.779	.000	2.083	
Average Cost Per Unit	69.47	11.05	901.25	22.20	.00	40.13	
Area Adjustment	1.013	1.000	1.000	1.000	1.000	1.000	
Adjusted Cost	$ 70.37	$ 11.05	$ 901.25	$ 22.20	$ .00	$ 40.13	
Interest Adjustment	.996	.999	.990	.994	.998	.995	
Contract Cost per Eligible	$ 318.06	$ 43.64	$ 405.08	$ 39.26	$ .00	$ 83.17	$ 889.21
Benefit Adjustments							
FY 94/95	1.003	.852	1.031	1.003	1.042	1.001	
FY 95/96	1.000	.724	1,018	1.000	1.020	.976	
Trend Adjustment 7/93 - 1/97	1.047	1.330	.807	.878	1.000	1.285	
Annual Cost Per Eligible	$ 334.01	$ 35.80	$ 343.10	$ 34.57	$ .00	$ 104.41	$ 851.89
Mental Health Adjustment	1.6%	4.6%	13.4%	2.9%	3.4%	3.6%	
Eyewear Adjustment						.9%	
Cost Excluding Mental Health	$ 328.67	$ 34.15	$ 297.12	$ 33.57	$ .00	$ 99.75	$ 793.26
Preliminary Monthly Rate							$ 66.11
Adj. for Fee-for-Service Limitation		-2.0%					$ -1.32
CHDP							2.38
Final Rate							$ 67.17

Attachment I

Plan Name: Mainstream
Plan Number:
County: San Bernardino
Aid Code: Aged

Base Period: CY '93
Rate Period: 6/96 - 9/97
Capitation Payable: End of Month

	Phys	Pharm	HIP	HOP	LTC	Other	Total
Units per 1,000 eligibles	4.280	19.624	1.476	1.310	2.880	14.314	
Age/sex Adjustment	.986	1.004	.995	.987	1.031	1.005	
Aid Code Adjustment	.936	1.021	.968	.931	1.007	1.016	
Adjusted Units	3.950	20.116	1.422	1.204	2.990	14.616	
Average Cost Per Unit	44.28	28.65	265.64	16.35	76.99	6.95	
Area Adjustment	1.013	1.000	1.000	1.000	1.000	1.000	
Adjusted Cost	$ 44.86	$ 28.65	$ 265.64	$ 16.35	$ 76.99	$ 6.95	
Interest Adjustment	.994	1.000	.990	.991	.998	.996	
Contract Cost per Eligible	$ 176.13	$ 576.32	$ 373.96	$ 19.51	$ 229.74	$ 101.17	$ 1,476.83
Benefit Adjustments							
FY 94/95	1.003	.852	1.036	1.003	1.042	1.001	
FY 95/96	1.000	.724	1.018	1.000	1.020	1.000	
Trend Adjustment 7/93 - 1/97	1.486	1.278	.896	1.127	1.075	1.565	
Annual Cost Per Eligible	$ 262.51	$ 454.33	$ 353.38	$ 22.05	$ 262.49	$ 158.49	$ 1,513.25
Mental Health Adjustment	.3%	3.2%	.7%	.9%	.4%	.0%	
Eyewear Adjustment						2.1%	
Cost Excluding Mental Health	$ 261.72	$ 439.79	$ 350.91	$ 21.85	$ 261.44	$ 155.16	$ 1,490.87
Preliminary Monthly Rate							$ 124.24
Adj. for Fee-for-Service Limitation		-2.0%					$ -2.48
CHDP							.00
Final Rate							$ 121.76

Attachment I

Plan Name: Mainstream
Plan Number:
County: San Bernardino
Aid Code: Disabled

Base Period: CY '93
Rate Period: 6/96 - 9/97
Capitation Payable: End of Month

	Phys	Pharm	HIP	HOP	LTC	Other	Total
Units per 1,000 eligibles	7.452	23.494	1.498	4.212	1.440	28.577	
Age/sex Adjustment	1.005	.979	.990	1.011	1.011	1.008	
Aid Code Adjustment	.994	1.003	.983	.993	.999	1.004	
Adjusted Units	7.444	23.070	1.458	4.229	1.454	28.921	
Average Cost Per Unit	43.31	32.19	511.29	18.05	108.27	10.65	
Area Adjustment	1.013	1.000	1.000	1.000	1.000	1.000	
Adjusted Cost	$ 43.87	$ 32.19	$ 511.29	$ 18.05	$ 108.27	$ 10.65	
Interest Adjustment	.995	.999	.991	.993	.999	.996	
Contract Cost per Eligible	$ 324.94	$ 741.88	$ 738.75	$ 75.80	$ 157.27	$ 306.78	$ 2,345.42
Benefit Adjustments							
FY 94/95	1.003	.852	1.036	1.003	1.042	1.001	
FY 95/96	1.000	.724	1.018	1.000	1.020	1.000	
Trend Adjustment 7/93 - 1/97	1.160	1.270	.981	1.065	.991	1.327	
Annual Cost Per Eligible	$ 378.06	$ 581.19	$ 764.32	$ 80.97	$ 165.65	$ 407.50	$ 2,377.69
Mental Health Adjustment	7.8%	18.8%	11.7%	2.4%	1.3%	1.4%	
Eyewear Adjustment						.9%	
Cost Excluding Mental Health	$ 348.57	$ 471.93	$ 674.89	$ 79.03	$ 163.50	$ 398.18	$ 2,136.10
Preliminary Monthly Rate							$ 178.01
Adj. for Fee-for-Service Limitation		-2.0%					$ -3.56
CHDP							.00
Final Rate							$ 174.45

Attachment I

Plan Name: Mainstream
Plan Number:
County: San Bernardino
Aid Code: Adult

Base Period: CY '93
Rate Period: 6/96 - 9/97
Capitation Payable: End of Month

	Phys	Pharm	HIP	HOP	LTC	Other	Total
Units per 1,000 eligibles	22.752	5.069	3.590	4.465	.000	20.412	
Age/sex Adjustment	1.000	1.000	1.000	1.000	1.000	1.000	
Aid Code Adjustment	1.000	1.000	1.000	1.000	1.000	1.000	
Adjusted Units	22.752	5.069	3.590	4.465	.000	20.412	
Average Cost Per Unit	59.80	16.00	960.30	20.51	.00	43.66	
Area Adjustment	1.013	1.000	1.000	1.000	1.000	1.000	
Adjusted Cost	$ 60.58	$ 16.00	$ 960.30	$ 20.51	$ .00	$ 43.66	
Interest Adjustment	.996	.999	.995	.993	.996	.995	
Contract Cost per Eligible	$ 1,372.80	$ 81.02	$ 3,430.24	$ 90.94	$ .00	$ 886.73	$ 5,861.73
Benefit Adjustments							
FY 94/95	1.003	.852	1.035	1.003	1.042	1.013	
FY 95/96	1.000	.724	1.018	1.000	1.020	1.000	
Trend Adjustment 7/93 - 1/97	1.099	1.023	1.126	1.169	1.000	1.195	
Annual Cost Per Eligible	$ 1,513.23	$ 51.13	$ 4,069.59	$ 106.63	$ .00	$ 1,073.42	$ 6,814.00
Mental Health Adjustment	.1%	2.2%	.3%	1.1%	.0%	.1%	
Eyewear Adjustment						.4%	
Cost Excluding Mental Health	$ 1,511.72	$ 50.01	$ 4,057.38	$ 105.46	$ .00	$ 1,068.06	$ 6,792.63
Preliminary Monthly Rate							$ 566.05
Adj. for Fee-for-Service Limitation		-2.0%					$ -11.32
CHDP							.00
Final Rate							$ 554.73

Attachment I

Plan Name: Mainstream
Plan Number:
County: Riverside
Aid Code: Family

Base Period: CY '93
Rate Period: 7/95 - 5/96
Capitation Payable: End of Month

	Phys	Pharm	HIP	HOP	LTC	Other	Total
Units per 1,000 eligibles	3.816	4.223	.370	2.232	.000	3.330	
Age/sex Adjustment	1.062	.994	1.094	1.032	1.000	1.021	
Aid Code Adjustment	1.029	.998	1.098	1.042	1.000	1.020	
Adjusted Units	4.170	4.189	.444	2.400	.000	3.468	
Average Cost Per Unit	71.93	14.73	828.49	21.79	369.03	28.02	
Area Adjustment	.986	1.000	1.000	1.000	1.000	1.000	
Adjusted Cost	$ 70.92	$ 14.73	$ 828.49	$ 21.79	$ 369.03	$ 28.02	
Interest Adjustment	.997	1.000	.994	.997	.997	.997	
Contract Cost per Eligible	$ 294.85	$ 61.70	$ 365.64	$ 52.14	$ .00	$ 96.88	$ 871.21
Benefit Adjustments							
FY 94/95	1.003	.852	1.030	1.003	1.042	1.013	
FY 95/96	1.000	.724	1.018	1.000	1.020	.976	
Trend Adjustment 7/93 - 1/96	1.027	1.220	1.043	.945	1.000	1.317	
Annual Cost Per Eligible	$ 303.72	$ 46.43	$ 399.87	$ 49.42	$ .00	$ 126.15	$ 925.59
Mental Health Adjustment	1.4%	.0%	6.6%	5.0%	1.5%	4.5%	
Eyewear Adjustment						1.5%	
Cost Excluding Mental Health	$ 299.47	$ 46.43	$ 373.48	$ 46.95	$ .00	$ 118.67	$ 885.00
Preliminary Monthly Rate							$ 73.75
Adj. for Fee-for-Service Limitation		-2.0%					$ -1.48
CHDP							2.43
Final Rate							$ 74.70

Attachment I

Plan Name: Mainstream
Plan Number:
County: Riverside
Aid Code: Child

Base Period: CY '93
Rate Period: 7/95 - 5/96
Capitation Payable: End of Month

	Phys	Pharm	HIP	HOP	LTC	Other	Total
Units per 1,000 eligibles	3.791	3.907	.361	1.620	.000	1.882	
Age/sex Adjustment	1.193	.991	1.245	1.064	1.000	1.114	
Aid Code Adjustment	1.020	1.035	1.048	1.013	1.000	1.025	
Adjusted Units	4.613	4.007	.471	1.746	.000	2.149	
Average Cost Per Unit	69.47	11.05	890.67	22.20	.00	40.13	
Area Adjustment	.986	1.000	1.000	1.000	1.000	1.000	
Adjusted Cost	$ 68.50	$ 11.05	$ 890.67	$ 22.20	$ .00	$ 40.13	
Interest Adjustment	.996	.999	.990	.994	.998	.995	
Contract Cost per Eligible	$ 314.73	$ 44.23	$ 415.31	$ 38.53	$ .00	$ 85.81	$ 898.61
Benefit Adjustments							
FY 94/95	1.003	.852	1.031	1.003	1.042	1.001	
FY 95/96	1.000	.724	1.018	1.000	1.020	.976	
Trend Adjustment 7/93 - 1/96	1.040	1.238	.853	.906	1.000	1.210	
Annual Cost Per Eligible	$ 328.30	$ 33.78	$ 371.82	$ 35.01	$ .00	$ 101.44	$ 870.35
Mental Health Adjustment	1.6%	.0%	13.4%	2.9%	3.4%	3.6%	
Eyewear Adjustment						.9%	
Cost Excluding Mental Health	$ 323.05	$ 33.78	$ 322.00	$ 33.99	$ .00	$ 96.91	$ 809.73
Preliminary Monthly Rate							$ 67.48
Adj. for Fee-for-Service Limitation		-2.0%					$ -1.35
CHDP							2.38
Final Rate							$ 68.51

Attachment I

Plan Name: Mainstream
Plan Number:
County: Riverside
Aid Code: Aged

Base Period: CY '93
Rate Period: 7/95 - 5/96
Capitation Payable: End of Month

	Phys	Pharm	HIP	HOP	LTC	Other	Total
Units per 1,000 eligibles	4.280	19.624	1.476	1.310	2.880	14.314	
Age/sex Adjustment	.991	1.002	1.000	.991	1.034	1.006	
Aid Code Adjustment	.941	1.015	.969	.932	1.004	1.003	
Adjusted Onits	3.991	19.958	1.430	1.210	2.990	14.443	
Average Cost Per Unit	44.28	28.65	205.53	16.35	76.99	6.95	
Area Adjustment	.986	1.000	1.000	1.000	1.000	1.000	
Adjusted Cost	$ 43.66	$ 28.65	$ 205.53	$ 16.35	$ 76.99	$ 6.95	
Interest Adjustment	.994	1.000	.990	.991	.998	.996	
Contract Cost per Eligible	$ 173.20	$ 571.80	$ 290.97	$ 19.61	$ 229.74	$ 99.98	$ 1,385.30
Benefit Adjustments							
FY 94/95	1.003	.852	1.036	1.003	1.042	1.001	
FY 95/96	1.000	.724	1.018	1.000	1.020	1.000	
Trend Adjustment 7/93 - 1/96	1.347	1.194	.925	1.091	1.054	1.404	
Annual Cost Per Eligible	$ 234.00	$ 421.14	$ 283.86	$ 21.46	$ 257.36	$ 140.51	$ 1,358.33
Mental Health Adjustment	.3%	.0%	.7%	.9%	.4%	.0%	
Eyewear Adjustment						2.1%	
Cost Excluding Mental Health	$ 233.30	$ 421.14	$ 281.87	$ 21.27	$ 256.33	$ 137.56	$ 1.351.47
Preliminary Monthly Rate							$ 112.62
Adj. for Fee-for-Service Limitation		-2.0%					$ -2.25
CHDP							.00
Final Rate							$ 110.37

Attachment I

Plan Name: Mainstream
Plan Number:
County: Riverside
Aid Code: Disabled

Base Period: CY '93
Rate Period: 7/95 - 5/96
Capitation Payable: End of Month

	Phys	Pharm	HIP	HOP	LTC	Other	Total
Units per 1,000 eligibles	7.452	23.494	1.498	4.212	1.440	28.577	
Age/sex Adjustment	1.003	.992	.992	1.003	1.012	1.005	
Aid Code Adjustment-	1.002	1.003	1.018	1.006	.997	1.005	
Adjusted Units	7.489	23.376	1.513	4.250	1.453	28.863	
Average Cost Per Unit	43.31	32.19	532.47	18.05	108.27	10.65	
Area Adjustment	.986	1.000	1.000	1.000	1.000	1.000	
Adjusted Cost	$ 42.70	$ 32.19	$ 532.47	$ 18.05	$ 108.27	$ 10.65	
Interest Adjustment	.995	.999	.991	.993	.999	.996	
Contract Cost per Eligible	$ 318.18	$ 751.72	$ 798.38	$ 76.18	$ 157.16	$ 306.16	$ 2,407.78
Benefit Adjustments							
FY 94/95	1.003	.852	1.036	1.003	1.042	1.001	
FY 95/96	1.000	.724	1.018	1.000	1.020	1.000	
Trend Adjustment 7/93 - 1/96	1.115	1.190	.986	1.047	.992	1.233	
Annual Cost Per Eligible	$ 355.84	$ 551.80	$ 830.22	$ 80.00	$ 165.70	$ 377.87	$ 2,361.43
Mental Health Adjustment	7.8%	.0%	11.7%	2.4%	1.3%	1.4%	
Eyewear Adjustment						.9%	
Cost Excluding Mental Health	$ 328.08	$ 551.80	$ 733.08	$ 78.08	$ 163.55	$ 369.23	$ 2,223.82
Preliminary Monthly Rate							$ 185.32
Adj. for Fee-for-Service Limitation		-2.0%					$ -3.71
CHDP							.00
Final Rate							$ 181.61

Attachment I

Plan Name: Mainstream
Plan Number:
County: Riverside
Aid Code: Adult

Base Period: CY '93
Rate Period: 7/95 - 5/96
Capitation Payable: End of Month

	Phys	Pharm	HIP	HOP	LTC	Other	Total
Units per 1,000 eligibles	22.752	5.069	3.590	4.465	.000	20.412	
Age/sex Adjustment	1.000	1.000	1.000	1.000	1.000	1.000	
Aid Code Adjustment	1.000	1.000	1.000	1.000	1.000	1.000	
Adjusted Units	22.752	5.069	3.590	4.465	.000	20.412	
Average Cost Per Unit	59.80	16.00	840.07	20.51	.00	43.66	
Area Adjustment	.986	1.000	1.000	1.000	1.000	1.000	
Adjusted Cost	$ 58.96	$ 16.00	$ 840.07	$ 20.51	$ .00	$ 43.66	
Interest Adjustment	.996	.999	.995	.993	.996	.995	
Contract Cost per Eligible	$ 1,336.09	$ 81.02	$ 3,000.77	$ 90.94	$ .00	$ 886.73	$ 5,395.55
Benefit Adjustments							
FY 94/95	1.003	.852	1.035	1.003	1.042	1.013	
FY 95/96	1.000	.724	1.018	1.000	1.020	1.000	
Trend Adjustment 7/93 - 1/96	1.076	1.020	1.086	1.122	1.000	1.139	
Annual Cost Per Eligible	$ 1,441.95	$ 50.98	$ 3,433.61	$ 102.34	$ .00	$ 1,023.12	$ 6,052.00
Mental Health Adjustment	.1%	.0%	.3%	1.1%	.0%	.1%	
Eyewear Adjustment						.4%	
Cost Excluding Mental Health	$ 1.440.51	$ 50.98	$ 3,423.31	$ 101.21	$ .00	$ 1,018.01	$ 6,034.02
Preliminary Monthly Rate							$ 502.84
Adj. for Fee-for-Service Limitation		-2.0%					$ -10.06
CHDP							.00
Final Rate							$ 492.78

Attachment I

Plan Name: Mainstream
Plan Number:
County: Riverside
Aid Code: Family

Base Period: CY '93
Rate Period: 6/96 - 9/97
Capitation Payable: End of Month

	Phys	Pharm	HIP	HOP	LTC	Other	Total
Units per 1,000 eligibles	8.816	4.223	.370	2.232	.000	3.330	
Age/sex Adjustment	1.062	.994	1.094	1.032	1.000	1.021	
Aid Code Adjustment	1.029	.998	1.098	1.042	1.000	1.020	
Adjusted Units	4.170	4.189	.444	2.400	.000	3.468	
Average Cost Per Unit	71.93	14.73	828.49	21.79	369.03	28.02	
Area Adjustment	.986	1.000	1.000	1.000	1.000	1.000	
Adjusted Cost	$ 70.92	$ 14.73	$ 828.49	$ 21.79	$ 369.03	$ 28.02	
Interest Adjustment	.997	1.000	.994	.997	.997	.997	
Contract Cost per Eligible	$ 294.85	$ 61.70	$ 365.64	$ 52.14	$ .00	$ 96.88	$ 871.21
Benefit Adjustments							
FY 94/95	1.003	.852	1.030	1.003	1.042	1.013	
FY 95/96	1.000	.724	1.018	1.000	1.020	.976	
Trend Adjustment 7/93 - 1/97	1.036	1.313	1.060	.925	1.000	1.454	
Annual Cost Per Eligible	$ 306.38	$ 49.97	$ 406.39	$ 48.37	$ .00	$ 139.27	$ 950.38
Mental Health Adjustment	1.4%	6.0%	6.5%	5.0%	1.5%	4.5%	
Eyewear Adjustment						1.5%	
Cost Excluding Mental Health	$ 302.09	$ 46.97	$ 379.57	$ 45.95	$ .00	$ 131.01	$ 905.59
Preliminary Monthly Rate							$ 75.47
Adj. for Fee-for-Service Limitation		-2.0%					$ -1.51
CHDP							2.43
Final Rate							$ 76.39

Attachment I

Plan Name: Mainstream
Plan Number:
County: Riverside
Aid Code: Child

Base Period: CY '93
Rate Period: 6/96 - 9/97
Capitation Payable: End of Month

	Phys	Pharm	HIP	HOP	LTC	Other	Total
Units per 1,000 eligibles	3.791	3.907	.361	1.620	.000	1.882	
Age/sex Adjustment	1.193	.991	1.245	1.064	1.000	1.114	
Aid Code Adjustment	1.020	1.035	1.048	1.013	1.000	1.025	
Adjusted Units	4.613	4.007	.471	1.746	.000	2.149	
Average Cost Per Unit	69.47	11.05	890.67	22.20	.00	40.13	
Area Adjustment	.986	1.000	1.000	1.000	1.000	1.000	
Adjusted Cost	$ 68.50	$ 11.05	$ 890.67	$ 22.20	$ .00	$ 40.13	
Interest Adjustment	.996	.999	.990	.994	.998	.995	
Contract Cost per Eligible	$ 314.73	$ 44.23	$ 415.31	$ 38.53	$ .00	$ 85.81	$ 898.61
Benefit Adjustments							
FY 94/95	1.003	.852	1.031	1.003	1.042	1.001	
FY 95/96	1.000	.724	1.018	1.000	1.020	.976	
Trend Adjustment 7/93 - 1/97	1.047	1.330	.807	.878	1.000	1.285	
Annual Cost Per Eligible	$ 330.51	$ 36.29	$ 351.76	$ 33.93	$ .00	$ 107.73	$ 860.22
Mental Health Adjustment	1.6%	4.6%	13.4%	2.9%	3.4%	3.6%	
Eyewear Adjustment						.9%	
Cost Excluding Mental Health	$ 325.22	$ 34.62	$ 304.62	$ 32.95	$ .00	$ 102.92	$ 800.33
Preliminary Monthly Rate							$ 66.69
Adj. for Fee-for-Service Limitation		-2.0%					$ -1.33
CHDP							2.38
Final Rate							$ 67.74

Attachment I

Plan Name: Mainstream
Plan Number:
County: Riverside
Aid Code: Aged

Base Period: CY '93
Rate Period: 6/96 - 9/97
Capitation Payable: End of Month

	Phys	Pharm	HIP	HOP	LTC	Other	Total
Units per 1.000 eligibles	4.280	19.624	1.476	1.310	2.880	14.314	
Age/sex Adjustment	.991	1.002	1.000	.991	1.034	1.006	
Aid Code Adjustment	.941	1.015	.969	.932	1.004	1.003	
Adjusted Units	3.991	19.958	1.430	1.210	2.990	14.443	
Average Cost Per Unit	44.28	28.65	205.53	16.35	76.99	6.95	
Area Adjustment	.986	1.000	1.000	1.000	1.000	1.000	
Adjusted Cost	$ 43.66	$ 28.65	$ 205.53	$ 16.35	$ 76.99	$ 6.95	
Interest Adjustment	.994	1.000	.990	.991	.998	.996	
Contract Cost per Eligible	$ 173.20	$ 571.80	$ 290.97	$ 19.61	$ 229.74	$ 99.98	$ 1,385.30
Benefit Adjustments							
FT 94/95	1.003	.852	1.036	1.003	1.042	1.001	
FY 95/96	1.000	.724	1.018	1.000	1.020	1.000	
Trend Adjustment 7/93 - 1/97	1.486	1.278	.896	1.127	1.075	1.565	
Annual Cost Per Eligible	$ 258.15	$ 450.77	$ 274.96	$ 22.17	$ 262.49	$ 156.63	$ 1,425.17
Mental Health Adjustment	.3%	3.2%	.7%	.9%	.4%	.0%	
Eyewear Adjustment						2.1%	
Cost Excluding Mental Health	$ 257.38	$ 436.35	$ 273.04	$ 21.97	$ 261.44	$ 153.34	$ 1,403.52
Preliminary Monthly Rate							$ 116.96
Adj. for Fee-for-Service Limitation		-2.0%					$ -2.34
CHDP							.00
Final Rate							$ 114.62

Attachment I

Plan Name: Mainstream
Plan Number:
County: Riverside
Aid Code: Disabled

Base Period: CY '93
Rate Period: 6/96 - 9/97
Capitation Payable: End of Month

	Phys	Pharm	HIP	HOP	LTC	Other	Total
Units per 1,000 eligibles	7.452	23.494	1.498	4.212	1.440	28.577	
Age/sex Adjustment	1.003	.992	.992	1.003	1.012	1.005	
Aid Code Adjustment	1.002	1.003	1.018	1.006	.997	1.005	
Adjusted Units	7.489	23.376	1.513	4.250	1.453	28.863	
Average Cost Per Unit	43.31	32.19	532.47	18.05	108.27	10.65	
Area Adjustment	.986	1.000	1.000	1.000	1.000	1.000	
Adjusted Cost	$ 42.70	$ 32.19	$ 532.47	$ 18.05	$ 108.27	$ 10.65	
Interest Adjustment	.995	.999	.991	.993	.999	.996	
Contract Cost per Eligible	$ 318.18	$ 751.72	$ 798.38	$ 76.18	$ 157.16	$ 306.16	$ 2,407.78
Benefit Adjustments							
FY 94/95	1.003	.852	1.036	1.003	1.042	1.001	
FY 95/96	1.000	.724	1.018	1.000	1.020	l.000	
Trend Adjustment 7/93 - 1/97	1.160	1.270	.981	1.065	.991	1.327	
Annual Cost Per Eligible	$ 370.20	$ 588.90	$ 826.01	$ 81.38	$ 165.53	$ 406.68	$ 2.438.70
Mental Health Adjustment	7.8%	18.8%	11.7%	2.4%	1.3%	1.4%	
Eyewear Adjustment						.9%	
Cost Excluding Mental Health	$ 341.32	$ 478.19	$ 729.37	$ 79.43	$ 163.38	$ 397.38	$ 2,189.07
Preliminary Monthly Rate							$ 182.42
Adj. for Fee-for-Service Limitation		-2.0%					$ -3.65
CHDP							.00
Final Rate							$ 178.77

Attachment I

Plan Name: Mainstream
Plan Number:
County: Riverside
Aid Code: Adult

Base Period: CY '93
Rate Period: 6/96 - 9/97
Capitation Payable: End of Month

	Phys	Pharm	HIP	HOP	LTC	Other	Total
Units per 1,000 eligibles	22.752	$ 5.069	3.590	4.465	.000	20.412	
Age/sex Adjustment	1.000	1.000	1.000	1.000	1.000	1.000	
Aid Code Adjustment	1.000	1.000	1.000	1.000	1.000	1.000	
Adjusted Units	22.752	5.069	3.590	4.465	.000	20.412	
Average Cost Per unit	59.80	16.00	840.07	20.51	.00	43.66	
Area Adjustment	.986	1.000	1.000	1.000	1.000	1.000	
Adjusted Cost	$ 58.96	$ 16.00	$ 840.07	$ 20.51	$ .00	$ 43.66	
Interest Adjustment	.996	.999	.995	.993	.996	.995	
Contract Cost per Eligible	$ 1,336.09	$ 81.02	$ 3,000.77	$ 90.94	$ .00	$ 886.73	$ 5,395.55
Benefit Adjustments							
FY 94/95	1.003	.852	1.035	1.003	1.042	1.013	
FY 95/96	1.000	.724	1.018	1.000	1.020	1.000	
Trend Adjustment 7/93 - 1/97	1.099	1.023	1.126	1.169	1.000	1.195	
Annual Cost Per Eligible	$ 1,472.77	$ 51.13	$ 3,560.08	$ 106.63	$ .00	$ 1,073.42	$ 6,264.03
Mental Health Adjustment	.1%	2.2%	.3%	1.1%	.0%	.1%	
Eyewear Adjustment						.4%	
Cost Excluding Mental Health	$ 1,471.30	$ 50.01	$ 3,549.40	$ 105.46	$ .00	$ 1,068.06	$ 6,244.23
Preliminary Monthly Rate							$ 520.35
Adj. for Fee-for-Service Limitation		-2.0%					$ -10.41
CHDP							.00
Final Rate							$ 509.94

STATE OF CALIFORNIA

STANDARD AGREEMENT -- APPROVED BY THE ATTORNEY GENERAL
STD.2(REV.5-91)

CONTRACT NUMBER 95-23637
AM. NO. 01
TAXPAYER'S FEDERAL EMPLOYER IDENTIFICATION NO. 33-0342719

THIS AGREEMENT, made and entered into this 30th day of May, 1997 in the State of California, by and between State of California, through its duly elected or appointed, qualified and acting

TITLE OF OFFICER ACTING FOR STATE
Chief, Program Support Branch

AGENCY
Department of Health Services, hereafter called the State, and

CONTRACTOR'S NAME
Molina Medical Centers, hereafter called the Contractor:

WTTNESSETH: That the Contractor for and in consideration of the covenants, conditions, agreements, and stipulations of the State hereinafter express does hereby agree to furnish to the State services and materials as follows: (Set forth service to be rendered by Contractor, amount to be paid Contractor, time for performance or completion, and attach plans and specifications, if any.)

Amendment A01 to contract number 95-23637 between Molina Medical Centers and the State of California; and

WHERE AS, the State of California and Molina Medical Centers, entered into a contract to provide health care services to Medi-Cal beneficiaries dated April 2, 1996; and

NOW THEREFORE, this contract is amended as follows:

[SEAL]

CONTINUED ON 1 SHEETS, EACH BEARING NAME OF CONTRACTOR AND CONTRACT NUMBER.

The provisions on the reverse side hereof constitute a part of this agreement. IN WITNESS WHEREOF, this agreement has been executed by the parties hereto, upon the date first above written.

STATE OF CALIFORNIA	CONTRACTOR		
AGENCY Department of Health Service	CONTRACTOR (If other than an individual, state whether a corporation, partnership, etc.) Molina Medical Centers		
BY (AUTHORIZED SIGNATURE) /s/ Jayna Querin For	BY (AUTHORIZED SIGNATURE) /s/ John Molina For		
PRINTED NAME OF PERSON SIGNING Edward E. Stahlberg	PRINTED NAME AND TITLE OF PERSON SIGNING J. Mario Molina, M.D., President		
TITLE Chief, Program Support Branch	ADDRESS One Golden Shore, Long Beach, CA 90802		
AMOUNT ENCUMBERED BY THIS DOCUMENT $ -0-	PROGRAM/CATEGORY (CODE AND TITLE) Loc. Asst. Section 14157 W&I Code	FUND TITLE Health Care Deposit	Department of General Services Use Only
PRIOR AMOUNT ENCUMBERED FOR THIS CONTRACT $ 226,553,310	(OPTIONAL USE) ITEM 4260-601-912 / CHAPTER 162 / STATUTE 1996 / FISCAL YEAR 96/97		
TOTAL AMOUNT ENCUMBERED TO $ 226,553,310	OBJECT OF EXPENDITURE (CODE AND TITLE) Fed. Cat. No. 93778 4260-101-001 & 890		Exempt from PCC per W&I Code Section 14087.4
I hereby certify upon my own personal knowledge that budgeted funds are available for the period and purpose of the expenditure stated above.	T.B.A. NO.	B.R. NO.	
SIGNATURE OF ACCOUNTING OFFICER /s/ Roberta Purser	DATE 6/26/97		

[ ] CONTRACTOR [ ] STATE AGENCY [ ] DEPT. OF GEN. SER. [ ] CONTROLLER [ ]

STATE OF CALIFORNIA

STANDARD AGREEMENT
STD 2 (REV.5-01)(REVERSE)

1. The Contractor agrees to indemnify, defend and save harmless the State, its officers, agents and employees from any and all claims and losses accruing or resulting to any and all contractors, subcontractors, materialmen, laborers and any other person, firm or corporation furnishing or supplying work services, materials or supplies in connection with the performance of this contract, and from any and all claims and losses accruing or resulting to any person, firm or corporation who may be injured or damaged by the Contractor in the performance of this contract.

2. The Contractor, and the agents and employees of Contractor, in the performance of the agreement, shall act in an independent capacity and not as officers or employees or agents of State of California.

3. The State may terminate this agreement and be relieved of the payment of any consideration to Contractor should Contractor fail to perform the covenants herein contained at the time and in the manner herein provided. In the event of such termination the State may proceed with the work in any manner deemed proper by the State. The cost to the State shall be deducted from any sum due the Contractor under this agreement, and the balance, if any, shall be paid the Contractor upon demand.

4. Without the written consent of the State, this agreement is not assignable by Contractor either in whole or in part.

5. Time is of the essence in this agreement.

6. No alteration or variation of the terms of this contract shall be valid unless made in writing and signed by the parties hereto, and no oral understanding or agreement not incorporated herein, shall be binding on any of the parties hereto.

7. The consideration to be paid Contractor, as provided herein, shall be in compensation for all of Contractor's expenses incurred in the performance hereof, including travel and per diem, unless otherwise expressly so provided.

Contract Amendment

The Department of Health Services ("DHS") and Molina Medical Centers ("Contractor") enter into this contract amendment as follows:

WHEREAS DHS and Contractor entered into contract number 95-23637 on April 2, 1996 (the "Contract"), identifying Contractor as the mainstream plan for the Medi-Cal Two Plan Model Program in San Bernardino and Riverside counties, and

WHEREAS DHS and Contractor desire to modify certain rights and obligations of the parties as they relate to termination of the Contract,

DHS and Contractor therefore mutually agree:

1. Section 3.17.6 is added to the Contract as though fully set forth therein:

(a) Notwithstanding any other provision of this Contract and except as provided in subsection (b), this Contract shall terminate on November 30, 1997, unless Contractor can accept enrollment on December 1, 1997, with coverage to be effective on December 1, 1997.

(b) The termination provisions of subsection (a) above, shall not apply if Contractor is unable to accept enrollment on December 1, 1997, as a result of (1) conditions, natural or otherwise, beyond the control of Contractor, which substantially interfere with normal business operations, or (2) legal, regulatory or other obstacles, unrelated to any act or omission of Contractor, that prevent, postpone or suspend commencement of the Two Plan Model Program in San Bernardino and Riverside counties.

(c) In the event of termination of the Contract pursuant to this section 3.17.6, Contractor waives any further notice and any administrative appeal rights otherwise arising from or associated with termination of the Contract pursuant to this section 3.17.6.

Department of Health Services	Molina Medical Centers
(signature)	(signature) /s/
(printed name)	(printed name) J. Mario Molina MD
(title)	(title) President
(date)	(date) 6/9/97

1. Article III, GENERAL TERMS AND CONDITIONS, is amended to add new Section 3.17.6, Termination-Other Conditions, as follows:

"3.17.6 Termination-Other Conditions

(a) Notwithstanding any other provision of this Contract and except as provided in subsection (b), this Contract will terminate on November 30, 1997, unless Contractor can accept enrollment on December 1, 1997, with coverage to be effective on December 1, 1997.

(b) The termination provisions of subsection (a) above, shall not apply if Contractor is unable to accept enrollment on December 1, 1997, as a result of (1) conditions, natural or otherwise, beyond the control of Contractor, which substantially interfere with normal business operations, or (2) legal, regulatory or other obstacles, unrelated to any act or omission of Contractor, that prevent, postpone or suspend commencement of the Two Plan Model Program in San Bernardino and Riverside counties.

(c) In the event of termination of the Contract pursuant to this section 3.17.6, Contractor waives any further notice and any administrative appeal rights otherwise arising from or associated with termination of the Contract pursuant to this section 3.17.6."

2. The effective date of this amendment is May 30, 1997.

3. All other rights, duties, obligations, and liabilities of the parties otherwise remain unchanged.

STATE OF CALIFORNIA

STANDARD AGREEMENT -- APPROVED BY THE ATTORNEY GENERAL
[STD. 2 (REV.5-91)

CONTRACT NUMBER 95-23637
AM. NO. 02

TAXPAYER'S FEDERAL EMPLOYER IDENTIFICATION NUMBER
33-0342719

THIS AGREEMENT, made and entered into this 1st day of July, 1997, in the State of California, by and between State of California, through its duly elected or appointed, qualified and acting

TITLE OF OFFICER ACTING FOR STATE
Chief, Program Support Branch

AGENCY
Department of Health Services, hereafter called the State, and

CONTRACTOR'S NAME
Molina Medical Centers, Inc., hereafter called the Contractor.

WITNESSETH: That the Contractor for and in consideration of the covenants, conditions, agreements, and stipulations of the State hereinafter expressed, does hereby agree to furnish to the State services and materials as follows: (Set forth service to be rendered by contractor, amount to be paid contractor, time for performance or completion, and attach plans and specifications, if any.)

Amendment A02 to contract number 95-23637 BETWEEN MOLINA MEDICAL CENTERS, INC. and the STATE OF CALIFORNIA; and

WHERE AS, the State of California and Molina Medical Centers, Inc., entered into a contract to provide health care services to eligible Medi-Cal beneficiaries, dated April 2, 1996; and

NOW THEREFORE, this Contract is amended as follows"

[SEAL]

CONTINUED ON 2 SHEETS, EACH BEARING NAME OF CONTRACTOR AND CONTRACT NUMBER.

The provisions on the reverse side hereof constitute a part of this agreement. IN WITNESS WHEREOF, this agreement has been executed by the parties hereto, upon the date first above written.

STATE OF CALIFORNIA	CONTRACTOR
AGENCY Department of Health Service	CONTRACTOR (if other than an individual, state whether a corporation, partnership, etc.) Molina Medical Centers, Inc., A CA Corporation
BY (AUTHORIZED SIGNATURE) /s/ Jayna Querin for	BY (AUTHORIZED SIGNATURE) /s/
PRINTED NAME OF PERSON SIGNING Edward E. Stahlberg	PRINTED NAME AND TITLE OF PERSON SIGNING J. Mario Molina, M.D.
TITLE Chief, Program Support Branch	ADDRESS One Golden Shore, Long Beach, CA 90802

AMOUNT ENCUMBERED BY THIS DOCUMENT
$ 194,472,680.00

PROGRAM/CATEGORY (CODE AND TITLE)
Loc. Asst.Sect. 14157 W&I Code

FUND TITLE
Health Care Deposit

DEPARTMENT OF GENERAL SERVICE USE ONLY

Exempt From PCC per W&I Code Section 14087.4

(OPTIONAL USE)

PRIOR AMOUNT ENCUMBERED FOR THIS CONTRACT
$ 226,553,310.00

ITEM	CHAPTER	STATUTE	FISCAL YEAR
4260-601-912	Subject to the Budget Act		

TOTAL AMOUNT ENCUMBERED TO DATE
421,025,990

OBJECT OF EXPENDITURE (CODE AND TITLE)
Fed.Cat.No.93778 4260-101-001 & 890

I hereby certify upon my own personal knowledge that budgeted funds are available for the period and purpose of the expenditure stated above.

T.B.A. NO. B.R. NO.

SIGNATURE OF ACCOUNTING OFFICER
/s/ Roberta Purser

DATE
7.8.97

[ ] CONTRACTOR [ ] STATE AGENCY [ ] DEPT. OF GEN. SER. [ ] CONTROLLER [ ]

1. The Contractor agrees to indemnify, defend and save harmless the state, its officers, agents and employees from any and all claims and losses accruing or resulting to any and all contractors, subcontractors, materialmen, laborers and any other person, firm or corporation furnishing or supplying work services, materials or supplies in connection with the performance of this contract, and from any and all claims and losses accruing or resulting to any person, firm or corporation who may be injured or damaged by the Contractor in the performance of this contract.

2. The Contractor, and the agents and employees of Contractor, in the performance of the agreement, shall act in an independent capacity and not as officers or employees or agents of State of California.

3. The State may terminate this agreement and be relieved of the payment of any consideration to Contractor should Contractor fail to perform the covenants herein contained at the time and in the manner herein provided. In the event of such termination the State may proceed with the work in any manner deemed proper by the State. The cost to the State shall be deducted from any sum due the Contractor under this agreement, and the balance, if any, shall be paid the Contractor upon demand.

4. Without the written consent of the State, this agreement is not assignable by Contractor either in whole or in part.

5. Time is of the essence in this agreement.

6. No alteration or variation of the terms of this contract shall be valid unless made in writing and signed by the parties hereto, and no oral understanding or agreement not incorporated herein, shall be binding on any of the parties hereto.

7. The consideration to be paid Contractor, as provided herein, shall be in compensation for all of Contractor's expenses incurred in the performance hereof, including travel and per diem, unless otherwise expressly so provided.

1, Article II, DEFINITIONS, Section O, Covered Services, is amended to add a new subparagraph 16, to read:

"16. HTV and AIDS drugs listed in Attachment II (consisting of one page), and HIV and AIDS drugs classified as Nucleoside Analogs, Protease Inhibitors, and Non-Nucleoside Reverse Transcriptase Inhibitors, approved by the federal Food and Drug Administration (FDA) after July 1, 1997."

2. Article V, PAYMENT PROVISIONS, Section 5.3, Capitation Rates, is amended to read as follows:

"5.3 CAPITATION RATES

DHS will remit to the Contractor a capitation payment each month for each Medi-Cal Member that appears on the approved list of Members supplied to the Contractor by DHS. The capitation rate shall be the amount specified in this Article. The payment period for health care services will commence on the first day of operations, as determined by DHS. Capitation payments will be made in accordance with the following schedule of capitation payment rates:

Aid Code Categories

Family: 01, 02, 08, 30, 32, 33, 34, 35, 38, 39, 3A, 3C, 3P, 3R, 40, 42, 4C, 4K, 54, 59, 5K; Aged: 10, 14, 16, 18; Disabled: 20 24, 26, 28, 36, 60, 64, 66, 68, 6A, 6C; Child: 03, 04, 45, 82; Adult: 86

For the Period 6/96 - 9/97

Riverside County		San Bernardino County	
Family	$ 76.81	Family	$ 72.12
Aged	$ 123.58	Aged	$ 130.50
Disabled	$ 190.62	Disabled	$ 186.32
Child	$ 68.08	Child	$ 67.51
Adult	$ 496.01	Adult	$ 538.82"

3. Article VI, SCOPE OF WORK, Section 6.5.7.8, Sensitive Services, is amended to add a new paragraph, to read:

   "The Contractor will develop, implement and maintain policies and procedures for the treatment of HIV infection and AIDS. These policies and procedures will be submitted to DHS no later than October 1, 1997. The Contractor will submit any changes in these policies and procedures to DHS at least 30 days prior to their implementation."

4. Article VI, SCOPE OF WORK, Section 6.7.3.3, Mental Health, is amended to read:

   "The following mental health services are excluded from the Contract: all of SD/MC mental health services (inpatient and outpatient); FFS/MC outpatient mental health services provided by psychiatrists and psychologists; FFS/MC inpatient mental health services.

   The Contractor will provide outpatient mental health services within the Primary Care Physician's scope of practice. The Contractor will refer Members who need specialty mental health services to the appropriate FFS/MC mental health provider or to the appropriate SD/MC provider. The Contractor will case manage the physical health of the Member and coordinate services with the mental health referral provider. The Contractor will ensure the provision of all psychotherapeutic drugs for Members. Reimbursement to pharmacies for those psychotherapeutic drugs listed in Attachment III (consisting of one page), and psychotherapeutic drugs classified as Anti-Psychotics and approved by the FDA after July 1, 1997, will be made by DHS through the Medi-Cal FFS program, whether these drugs are provided by a pharmacy contracting with the Contractor or by an out-of-plan pharmacy provider. To qualify for reimbursement under this provision, a pharmacy must be enrolled as a Medi-Cal provider in the Medi-Cal FFS program."

5. The effective date of this amendment will be July 1, 1997.

6. All other rights, duties, obligations and liabilities of the parties hereto otherwise remain unchanged.

ATTACHMENT II

EXCLUDED DRUGS FOR THE TREATMENT OF HIV AND AIDS

CRIXIVAN

EPIVIR

INVIRASE

NORVIR

VIRACEPT

VIRAMUNE

RESCRIPTOR

ZERIT

ATTACHMENT III

EXCLUDED PSYCHOTHERAPEUTIC DRUGS

GENERIC NAME

Benztropine Mesylate	Biperiden HCL
Biperiden Lactate	Procyclidine HCL
Trihexphenidyl HCL	Amantadine HCL
Lithium Carbonate	Lithium Citrate
Chloroprothixene	Clozapine
Haloperidol	Haloperidol Deconoate
Haloperidol Lactate	Loxapine HCL
Loxapine Succinate	Molindone HCL
Olanzapine	Pimozide
Risperidone	Thiothixene
Thiothixene HCL	Chlorpromazine HCL
Fluphanazine Decanoate	Fluphanazine Enanthate
Fluphanazine HCL	Mesoridazine Besylate
Perphenazine	Promazine HCL
Thioridazine HCL	Trifluoperazine HCL
Triflupromazine HCL	Isocarboxazid
Phenelzine Sulfate	Tranylcypromine Sulfate

MOLINA MEDICAL CENTERS, INC. 95-23637-02

Plan Name Molina Medical Center
Plan Number 355
County Riverside

Date: 6/24/1997
Base Period: CY '93
Rate Period: 6/96 - 9/97

Aid Code Group Family

		Phys	Pharm	HIP	HOP	LTC	Other	Total
1.	Base Units per Eligible	3.816	4.223	.370	2.232	.000	3.330	
2.	Aid Code Adjustment	1.029	.998	1.098	1.042	1.000	1.020	
3.	Age/sex Adjustment	1.062	.994	1.094	1.032	1.000	1.021	
	Adjusted Units	4.170	4.189	.444	2.400	.000	3.468	
4.	Average Cost Per Unit	71.93	14.73	828.49	21.79	369.03	28.02	
5.	Area Adjustment	.986	1.000	1.000	1.000	1.000	1.000	
	Adjusted Cost	$ 70.92	$ 14.73	$ 828.49	$ 21.79	$ 369.03	$ 28.02	
6.	Interest Adjustment	.993	.996	.990	.993	.993	.993	
	Contract Cost per Eligible	$ 293.67	$ 61.46	$ 364.17	$ 51.93	$ .00	$ 96.49	$ 867.72
7.	Benefit Adjustments							
	FY 94/95	1.021	.926	1.002	1.002	1.042	1.025	
	FY 95/96	1.001	.850	1.000	1.000	.999	.991	
8.	Trend Adjustment 7/93-1/97	1.036	1.313	1.060	.925	1.000	1.454	
	Annual Cost Per Eligible	$ 310.94	$ 63.52	$ 386.79	$ 48.13	$ .00	$ 142.51	$ 951.89
9.	Mental Health Adjustment	1.4%	.6%	6.6%	5.0%	1.5%	4.5%	
10.	Lenses Adjustment						1.5%	
	Cost Excl. MH/Lenses	$ 306.59	$ 63.14	$ 361.26	$ 45.72	$ .00	$ 134.06	$ 910.77
	Preliminary Monthly Rate							$ 75.90
11.	Stop Loss Reinsurance - All Services		0			.0%		.00
12.	Adjustment for FFS Limitation					-2%		(1.52)
13.	CHDP							2.43
14.	FQHC Incremental Amount							.00
	Final Monthly Rate - Capitation Payments at Beginning of Month							$ 76.81

MOLINA MEDICAL CENTERS, INC. 95-23637-02

Plan Name Molina Medical Center
Plan Number 355
County Riverside

Date: 6/24/1997
Base Period: CY '93
Rate Period: 6/96 - 9/97

Aid Code Group Aged

		Phys	Pharm	HIP	HOP	LTC	Other	Total
1.	Base Units per Eligible	4. 280	19.624	1.476	1.310	2.880	14.314	
2.	Aid Code Adjustment	.941	1.015	.969	.932	1.004	1.003	
3.	Age/sex Adjustment	.991	1.002	1.000	.991	1.034	1.006	
	Adjusted Units	3.991	19.958	1.430	1.210	2.990	14.443	
4.	Average Cost Per Unit	44.28	28.65	205.53	16.35	76.99	6.95	
5.	Area Adjustment	.986	1.000	1.000	1.000	1.000	1.000	
	Adjusted Cost	$ 43.66	$ 28.65	$ 205.53	$ 16.35	$ 76.99	$ 6.95	
6.	Interest Adjustment	.991	.996	.986	.988	.994	.992	
	Contract Cost per Eligible	$ 172.68	$ 569.51	$ 289.79	$ 19.55	$ 228.82	$ 99.58	$ 1,379.93
7.	Benefit Adjustments							
	FY 94/95	1.002	.926	1.008	1.002	1.042	1.000	
	FY 95/96	1.000	.850	1.000	1.000	.989	1.000	
8.	Trend Adjustment 7/93-1/97	1.486	1.278	.896	1.127	1.075	1.565	
	Annual Cost Per Eligible	$ 257.12	$ 572.88	$ 261.73	$ 22.08	$ 253.49	$ 155.84	$ 1,523.14
9.	Mental Health Adjustment	.3%	.5%	.7%	.9%	.4%	.0%	
10.	Lenses Adjustment						2.1%	
	Cost Excl. MH/Lenses	$ 256.35	$ 570.02	$ 259.90	$ 21.88	$ 252.48	$ 152.57	$ 1,513.20
	Preliminary Monthly Rate							$ 126.10
11.	Stop Loss Reinsurance - All Services		0			.0%		.00
12.	Adjustment for FFS Limitation					-2%		(2.52)
13.	CHDP							.00
14.	FQHC Incremental Amount							.00
	Final Monthly Rate - Capitation Payments at Beginning of Month							$ 123.58

MOLINA MEDICAL CENTERS, INC. 95-23637-02

Plan Name Molina Medical Center
Plan Number 355
County Riverside

Date: 6/24/1997
Base Period: CY '93
Rate Period: 6/96 - 9/97

Aid Code Group Disabled

		Phys	Pharm	HIP	HOP	LTC	Other	Total
1.	Base Units per Eligible	7.452	23.494	1.498	4.212	1.440	28.577	
2.	Aid Code Adjustment	1.002	1.003	1.018	1.006	.997	1.005	
3.	Age/sex Adjustment	1.003	.992	.992	1.003	1.012	1.005	
	Adjusted Units	7.489	23.376	1.513	4.250	1.453	28.863	
4.	Average Cost Per Unit	43.31	32.19	532.47	18.05	108.27	10.65	
5.	Area Adjustment	.986	1.000	1.000	1.000	1.000	1.000	
	Adjusted Cost	$ 42.70	$ 32.19	$ 532.47	$ 18.05	$ 108.27	$ 10.65	
6.	Interest Adjustment	.992	.996	.998	.990	.995	.992	
	Contract Cost per Eligible	$ 317.22	$ 749.46	$ 795.96	$ 75.95	$ 156.53	$ 304.93	$ 2,400.05
7.	Benefit Adjustments							
	FY 94/95	1.002	.926	1.005	1.002	1.042	1.000	
	FY 95/96	1.000	.850	1.000	1.000	.989	1.000	
8.	Trend Adjustment 7/93-1/97	1.160	1.270	.981	1.065	.991	1.327	
	Annual Cost Per Eligible	$ 368.71	$ 749.17	$ 784.74	$ 81.05	$ 159.86	$ 404.64	$ 2,548.17
9.	Mental Health Adjustment	7.8%	10.7%	11.7%	2.4%	1.3%	1.4%	
10.	Lenses Adjustment						.9%	
	Cost Excl. MH/Lenses	$ 339.95	$ 669.01	$ 692.93	$ 79.10	$ 157.78	$ 395.38	$ 2,334.15
	Preliminary Monthly Rate							$ 194.51
11.	Stop Loss Reinsurance - All Services		0			.0%		.00
12.	Adjustment for FFS Limitation					-2%		(3.89)
13.	CHDP							.00
14.	FQHC Incremental Amount							.00
	Final Monthly Rate - capitation Payments at Beginning of Month							$ 190.62

MOLINA MEDICAL CENTERS, INC. 95-23637-02

Plan Name Molina Medical Center
Plan Number 355
County Riverside

Date: 6/24/1997
Base Period: CY '93
Rate Period: 6/96 - 9/97

Aid Code Group Child

	Phys	Pharm	HIP	HOP	LTC	Other	Total
1. Base Units per Eligible	3.791	3.907	.361	1.620	.000	1.882	
2. Aid Code Adjustment	1.020	1.035	1.048	1.013	1.000	1.025	
3. Age/sex Adjustment	1.193	.992	1.245	1.064	1.000	1.114	
Adjusted Units	4.613	4.007	.471	1.746	.000	2.149	
4. Average Cost Per Unit	69.47	11.05	890.67	22.20	.00	40.13	
5. Area Adjustment	.986	1.000	1.000	1.000	1.000	1.000	
Adjusted Cost	$ 68.50	$ 11.05	$ 890.67	$ 22.20	$ .00	$ 40.13	
6. Interest Adjustment	.992	.995	.987	.990	.994	.992	
Contract Cost per Eligible	$ 313.46	$ 44.06	$ 414.05	$ 38.37	$ .00	$ 85.55	$ 895.49
7. Benefit Adjustments							
FY 94/95	1.021	.926	1.002	1.002	1.042	1.019	
FY 95/96	1.001	.850	1.000	1.000	.989	.991	
8. Trend Adjustment 7/93-1/97	1.047	1.330	.807	.878	1.000	1.285	
Annual Cost Per Eligible	$ 336.42	$ 46.12	$ 334.81	$ 33.76	$ .00	$ 111.01	$ 861.12
9. Mental Health Adjustment	1.6%	1.1%	13.4%	2.9%	3.4%	3.6%	
10. Lenses Adjustment						.9%	
Cost Excl. MH/Lenses	$ 330.05	$ 45.61	$ 289.95	$ 32.78	$ .00	$ 106.05	$ 804.44
Preliminary Monthly Rate							$ 67.04
11. Stop Loss Reinsurance - All Services		0			.0%		.00
12. Adjustment for FFS Limitation					-2%		(1.34)
13. CHDP							2.38
14. FQHC Incremental Amount							.00
Final Monthly Rate - Capitation Payments at Beginning of Month							$ 68.08

MOLINA MEDICAL CENTERS, INC. 95-23637-02

Plan Name Molina Medical Center
Plan Number 355
County Riverside

Date: 6/24/1997
Base Period: CY '93
Rate Period: 6/96 - 9/97

Aid Code Group Adult

		Phys	Pharm	HIP	HOP	LTC	Other	Total
1.	Base Units per Eligible	22.752	5.069	3.590	4.465	.000	20.412	
2.	Aid Code Adjustment	1.000	1.000	1.000	1.000	1.000	1.000	
3.	Age/sex Adjustment	1.000	1.000	1.000	1.000	1.000	1.000	
	Adjusted Units	22.752	5.069	3.590	4.465	.000	20.412	
4.	Average Cost Per Unit	59.80	16.00	840.07	20.51	.00	43.66	
5.	Area Adjustment	.986	1.000	1.000	1.000	1.000	1.000	
	Adjusted Cost	$ 58.96	$ 16.00	$ 840.07	$ 20.51	$ .00	$ 43.66	
6.	Interest Adjustment	.993	.996	.991	.989	.993	.991	
	Contract Cost per Eligible	$ 1,332.07	$ 80.78	$ 2,988.71	$ 90.57	$ .00	$ 883.17	$ 5,375.30
7.	Benefit Adjustments							
	FY 94/95	1.002	.926	1.008	1.002	1.042	1.006	
	PY 95/96	1.000	.850	1.000	1.000	.985	1.000	
8.	Trend Adjustment 7/93-1/97	1.099	1.023	1.126	1.169	1.000	1.195	
	Annual Cost Per Eligible	$ 1,466.87	$ 65.04	$ 3,392.21	$ 106.09	$ .00	$ 1,061.72	$ 6,091.93
9.	Mental Health Adjustment	.1%	.4%	.3%	1.1%	.0%	.1%	
10.	Lenses Adjustment						.4%	
	Cost Excl.MH/Lenses	$ 1,465.40	$ 64.78	$ 3,382.03	$ 104.92	$ .00	$ 1,056.42	$ 6,073.55
	Preliminary Monthly Rate							$ 506.13
11.	Stop Loss Reinsurance - All Services		0			.0%		.00
12.	Adjustment for FFS Limitation					-2%		(10.12)
13.	CHDP							.00
14.	FQHC Incremental Amount							.00
	Final Monthly Rate - Capitation Payments at Beginning of Month							$ 496.01

MOLINA MEDICAL CENTERS, INC. 95-23637-02

Plan Name Molina Medical Center
Plan Number 356
County San Bernardino

Date: 6/24/1997
Base Period: CY '93
Rate Period: 6/96 - 9/97

Aid Code Group Family

		Phys	Pharm	HIP	HOP	LTC	Other	Total
1.	Base Units per Eligible	3.816	4.223	.370	2.232	.000	3.330	
2.	Aid Code Adjustment	.989	.990	.985	.995	1.000	.976	
3.	Age/sex Adjustment	1.026	.997	1.040	1.019	1.000	1.010	
	Adjusted Units	3.872	4.168	.379	2.263	.000	3.283	
4.	Average Cost Per Unit	71.93	14.73	880.94	21.79	369.03	28.02	
5.	Area Adjustment	1.013	1.000	1.000	1.000	1.000	1.000	
	Adjusted Cost	$ 72.87	$ 14.73	$ 880.94	$ 21.79	$ 369.03	$ 28.02	
6.	Interest Adjustment	.993	.996	.990	.993	.993	.993	
	Contract Cost per Eligible	$ 280.18	$ 61.15	$ 330.54	$ 48.97	$ .00	$ 91.35	$ 812.19
7.	Benefit Adjustments							
	FY 94/95	1.021	.926	1.002	1.002	1.042	1.025	
	FY 95/96	1.001	.850	1.000	1.000	.989	.991	
8.	Trend Adjustment 7/93-1/97	1.036	1.313	1.060	.926	1.000	1.454	
	Annual Cost Per Eligible	$ 296.66	$ 63.20	$ 351.07	$ 45.39	$ .00	$ 134.92	$ 891.24
9.	Mental Health Adjustment	1.4%	.6%	6.6%	5.0%	1.5%	4.5%	
10.	Lenses Adjustment						1.5%	
	Cost Excl. MH/Lenses	$ 292.51	$ 62.82	$ 327.90	$ 43.12	$ .00	$ 126.92	$ 853.27
	Preliminary Monthly Rate							$ 71.11
11.	Stop Loss Reinsurance - All Services		0			.0%		.00
12.	Adjustment for FFS Limitation					-2%		(1.42)
13.	CHDP							2.43
14.	FQHC Incremental Amount							.00
	Final Monthly Rate - Capitation Payments at Beginning of Month							$ 72.12

MOLINA MEDICAL CENTERS, INC. 95-23637-02

Plan Name Molina Medical Center
Plan Number 356
County San Bernardino

Date: 6/24/1997
Base Period: CY '93
Rate Period: 6/96 - 9/97

Aid Code Group Aged

		Phys	Pharm	HIP	HOP	LTC	Other	Total
1.	Base Units per Eligible	4.280	19.624	1.476	1.310	2.880	14.314	
2.	Aid Code Adjustment	.936	1.021	.968	.931	1.007	1.016	
3.	Age/sex Adjustment	.986	1.004	.995	.987	1.031	1.005	
	Adjusted Units	3.950	20.116	1.422	1.204	2.990	14.616	
4.	Average Cost Per Unit	44.28	28.65	265.64	16.35	76.99	6.95	
5.	Area Adjustment	1.013	1.000	1.000	1.000	1.000	1.000	
	Adjusted Cost	$ 44.86	$ 28.65	$ 265.64	$ 16.35	$ 76.99	$ 6.95	
6.	Interest Adjustment	.991	.996	.986	.988	.994	.992	
	Contract Cost per Eligible	$ 175.60	$ 574.02	$ 372.45	$ 19.45	$ 228.82	$ 100.77	$ 1,471.11
7.	Benefit Adjustments							
	FY 94/95	1.002	.926	1.008	1.002	1.042	1.000	
	FY 95/96	1.000	.850	1.000	1.000	.989	1.000	
8.	Trend Adjustment 7/93-1/97	1.486	1.278	.896	1.127	1.075	1.565	
	Annual Cost Per Eligible	$ 261.46	$ 577.41	$ 336.38	$ 21.96	$ 253.49	$ 157.71	$ 1,608.41
9.	Mental Health Adjustment	.3%	.5%	.7%	.9%	.4%	.0%	
10.	Lenses Adjustment						2.1%	
	Cost Excl. MH/Lenses	$ 260.68	$ 574.52	$ 334.03	$ 21.76	$ 252.48	$ 154.40	$ 1,597.87
	Preliminary Monthly Rate							$ 133.16
11.	Stop Loss Reinsurance - All Services		0			.0%		.00
12.	Adjustment for FFS Limitation					-2%		(2.66)
13.	CHDP							.00
14.	FQHC Incremental Amount							.00
	Final Monthly Rate - Capitation Payments at Beginning of Month							$ 130.50

MOLINA MEDICAL CENTERS, INC. 95-23637-02

Plan Name	Molina Medical Center	Date:	6/24/1997
Plan Number	356	Base Period:	CY '93
County	San Bernardino	Rate Period:	6/96 - 9/97

Aid Code Group Disabled

		Phys	Pharm	HIP	HOP	LTC	Other	Total
1.	Base Units per Eligible	7.452	23.494	1.498	4.212	1.440	28.577	
2.	Aid Code Adjustment	.994	1.003	.983	.993	.999	1.004	
3.	Age/sex Adjustment	1.005	.979	.990	1.011	1.011	1.008	
	Adjusted Units	7.444	23.070	1.458	4.229	1.454	28.921	
4.	Average Cost Per Unit	43.31	32.19	511.29	18.05	108.27	10.65	
5.	Area Adjustment	1.013	1.000	1.000	1.000	1.000	1.000	
	Adjusted Cost	$ 43.87	$ 32.19	$ 511.29	$ 18.05	$ 108.27	$ 10.65	
6.	Interest Adjustment	.992	.996	.988	.990	.995	.992	
	Contract Cost per Eligible	$ 323.96	$ 739.65	$ 736.52	$ 75.57	$ 156.64	$ 305.54	$ 2,337.88
7.	Benefit Adjustments							
	FY 94/95	1.002	.926	1.005	1.002	1.042	1.000	
	FY 95/96	1.000	.850	1.000	1.000	.989	1.000	
8.	Trend Adjustment 7/93-1/97	1.160	1.270	.981	1.065	.991	1.327	
	Annual Cost Per Eligible	$ 376.55	$ 739.37	$ 726.14	$ 80.64	$ 159.97	$ 405.45	$ 2,488.12
9.	Mental Health Adjustment	7.8%	10.7%	11.7%	2.4%	1.3%	1.4%	
10.	Lenses Adjustment						.9%	
	Cost Excl. MH/Lenses	$ 347.18	$ 660.26	$ 641.18	$ 78.70	$ 157.89	$ 396.18	$ 2,281.39
	Preliminary Monthly Rate							$ 190.12
11.	Stop Loss Reinsurance - All Services		0			.0%		.00
12.	Adjustment for FFS Limitation					-2%		(3.80)
13.	CHDP							.00
14.	FQHC Incremental Amount							.00
	Final Monthly Rate - Capitation Payments at Beginning of Month							$ 186.32

MOLINA MEDICAL CENTERS, INC. 95-23637-02

Plan Name Molina Medical Center
Plan Number 356
County San Bernardino

Date: 6/24/1997
Base Period: CY '93
Rate Period: 6/96 - 9/97

Aid Code Group Child

		Phys	Pharm	HIP	HOP	LTC	Other	Total
1.	Base Units per Eligible	3.791	3.907	.361	1.620	.000	1.882	
2.	Aid Code Adjustment	1.011	.993	1.025	1.010	1.000	.998	
3.	Age/sex Adjustment	1.184	1.019	1.227	1.087	1.000	1.109	
	Adjusted Units	4.538	3.953	.454	1.779	.000	2.083	
4.	Average Cost Per Unit	69.47	11.05	901.25	22.20	.00	40.13	
5.	Area Adjustment	1.013	1.000	1.000	1.000	1.000	1.000	
	Adjusted Cost	$ 70.37	$ 11.05	$ 901.25	$ 22.20	$ .00	$ 40.13	
6.	Interest Adjustment	.992	.995	.987	.990	.994	.992	
	Contract Cost per Eligible	$ 316.78	$ 43.46	$ 403.85	$ 39.10	$ .00	$ 82.92	$ 886.11
7.	Benefit Adjustments							
	FY 94/95	1.021	.926	1.002	1.002	1.042	1.019	
	FY 95/96	1.001	.850	1.000	1.000	.989	.991	
8.	Trend Adjustment 7/93-1/97	1.047	1.330	.807	.878	1.000	1.285	
	Annual Cost Per Eligible	$ 338.97	$ 45.50	$ 326.56	$ 34.40	$ .00	$ 107.60	$ 853.03
9.	Mental Health Adjustment	1.6%	1.1%	13.4%	2.9%	3.4%	3.6%	
10.	Lenses Adjustment						.9%	
	Cost Excl. MH/Lenses	$ 333.55	$ 45.00	$ 282.80	$ 33.40	$ .00	$ 102.79	$ 797.54
	Preliminary Monthly Rate							$ 66.46
11.	Stop Loss Reinsurance - All Services		0			.0%		.00
12.	Adjustment for FFS Limitation					-2%		(1.33)
13.	CHDP							2.38
14.	FQHC Incremental Amount							.00
	Final Monthly Rate - Capitation Payments at Beginning of Month							$ 67.51

MOLINA MEDICAL CENTERS, INC. 95-23637-02

Plan Name Molina Medical Center
Plan Number 356
County San Bernardino
Aid Code Group Adult

Date: 6/24/1997
Base Period: CY '93
Rate Period: 6/96 - 9/97

		Phys	Pharm	HIP	HOP	LTC	Other	Total
1.	Base Units per Eligible	22.752	5.069	3.590	4.465	.000	20.412	
2.	Aid Code Adjustment	1.000	1.000	1.000	1.000	1.000	1.000	
3.	Age/sex Adjustment	1.000	1.000	1.000	1.000	1.000	1.000	
	Adjusted Units	22.752	5.069	3.590	4.465	.000	20.412	
4.	Average Cost Per Unit	59.80	16.00	960.30	20.51	.00	43.66	
5.	Area Adjustment	1.013	1.000	1.000	1.000	1.000	1.000	
	Adjusted Cost	$ 60.58	$ 16.00	$ 960.30	$ 20.51	$ .00	$ 43.66	
6.	Interest Adjustment	.993	.996	.991	.989	.993	.991	
	Contract Cost per Eligible	$ 1,368.67	$ 80.78	$ 3,416.45	$ 90.57	$ .00	$ 883.17	$ 5,839.64
7.	Benefit Adjustments							
	FY 94/95	1.002	.926	1.008	1.002	1.042	1.006	
	FY 95/96	1.000	.850	1.000	1.000	.989	1.000	
8.	Trend Adjustment 7/93-1/97	1.099	1.023	1.126	1.169	1.000	1.195	
	Annual Cost per Eligible	$ 1,507.18	$ 65.04	$ 3,877.70	$ 106.09	$ .00	$ 1,061.72	$ 6,617.73
9.	Mental Health Adjustment	.1%	.4%	.3%	1.1%	.0%	.1%	
10.	Lenses Adjustment						.4%	
	Cost Excl. MH/Lenses	$ 1,505.67	$ 64.78	$ 3.866.07	$ 104.92	$ .00	$ 1,056.42	$ 6,597.86
	Preliminary Monthly Rate							$ 549.82
11.	Stop Loss Reinsurance - All Services		0			.0%		.00
12.	Adjustment for FFS Limitation					-2%		(11.00)
13.	CHDP							.00
14.	FQHC Incremental Amount							.00
	Final Monthly Rate - Capitation Payments at Beginning of Month							$ 538.82

STATE OF CALIFORNIA

STANDARD AGREEMENT -- APPROVED BY THE ATTORNEY GENERAL
(REV.5-91)

CONTRACT NUMBER: 95-23637 AM. NO.: 03

TAXPAYER'S FEDERAL EMPLOYER IDENTIFICATION NUMBER: 33-0342719

THIS AGREEMENT, made and entered into this 1st day of October, 1998, in the State of California, by and between State of California, through its duly elected or appointed, qualified and acting

TITLE Of OFFICER ACTING FOR STATE: Chief, Program Support Branch

AGENCY: Department of Health Services, hereafter called the State, and

CONTRACTORS NAME: Molina Medical Centers, Inc., hereafter called the Contractor

WITNESSETH: That the Contractor for and in consideration of the covenants, conditions, agreements, and stipulations of the State hereinafter expressed does hereby agree to furnish to the State services and materials as follows: (Set forth service to be rendered by Contractor, amount to be paid Contractor time for performance or completion, and attach plans and specifications, if any.)

Amendment A03 to Contract no. 95-23637 BETWEEN MOLINA MEDICAL CENTERS, INC., and the STATE OF CALIFORNIA,

WHEREAS, the State of California and Molina Medical Centers, Inc., entered into a contract to provide health care services to Medi-Cal beneficiaries dated April 2, 1996; and

NOW THEREFORE, this Contract is amended as follows:

[SEAL]

CONTINUED ON 98 SHEETS, EACH BEARING NAME OF CONTRACTOR AND CONTRACT NUMBER.

The provisions on the reverse side hereof constitutes a part of this agreement.
IN WITNESS WHEREOF, this agreement has been executed by the parties hereto, upon the date first above written.

STATE OF CALIFORNIA	CONTRACTOR
AGENCY Department of Health Services	CONTRACTOR (IF other than an individual, state whether a corporation, partnership, etc.) Molina Medical Centers, Inc.
BY (AUTHORIZED SIGNATURE) /s/ Jayne Querin for	BY (AUTHORIZED SIGNATURE) /s/
PRINTED NAME OF PERSON SIGNING Edward E. Stahlberg	PRINTED NAME AND TITLE OF PERSON SIGNING J. Mario Molina, M.D.
TITLE Chief, Program Support Branch	ADDRESS One Golden Shore, Long Beach, CA 90802

AMOUNT ENCUMBERED BY THIS DOCUMENT
$ [187,972,680] 97/98
$ [114,472,680] 98/99

PROGRAM/CATEGORY (CODE AND TITLE): Loc. Asst.Section 14157 W&I Code

FUND TITLE: Health Care Deposit

(OPTIONAL USE)

Department of General Services Use Only

Exempt From PCC per W&I Code Section 14087.4

PRIOR AMOUNT ENCUMBERED FOR THIS CONTRACT
$ 615,498,670

ITEM	CHAPTER	STATUTE	FISCAL YEAR
	282	1997	97/98
4260-601-912	324	1998	98/99

TOTAL AMOUNT ENCUMBERED TO DATE
3,058,310

OBJECT OF EXPENDITURE (CODE AND TITLE): 9912-705-95915

I hereby certify upon my own personal knowledge that budgeted funds are available for the period and purpose of the expenditure stated above.

T.B.A. NO. B.R. NO.

SIGNATURE OF ACCOUNTING OFFICER: /s/ Sharon Flaherty

DATE: 11.19.98

[ ] CONTRACTOR [ ] STATE AGENCY [ ] DEPT. OF GEN. SER. [ ] CONTROLLER [ ]

1. The contractor agrees to indemnify, defend and save harmless the State, its officers, agents and employees from any and are claims and losses accruing or resulting to any and all contractors, subcontractors, materialmen, laborers and any other person, firm or corporation furnishing or supplying work services, materials or supplies in connection with the performance of this contract, and from any and all claims and losses accruing or resulting to any person, firm or corporation who may be injured or damaged by the Contractor in the performance of this contract.

2. The Contractor, and the agents and employees of Contractor, in the performance of the agreement, shall act in an independent capacity and not as officers or employees or agents of State of California.

3. The State may terminate this agreement and be relieved of the payment of any consideration to Contractor should Contractor fail to perform the covenants herein contained at the time and in the manner herein provided. In the event of such termination the State may proceed with the work in any manner deemed proper by the State. The cost to the state shall be deducted from any sum due the Contractor under this agreement, and the balance, if any, shall be paid the Contractor upon demand.

4. Without the written consent of the State, this agreement is not assignable by Contractor either in whole or in part.

5. Time is the essence of this agreement.

6. No alteration or variation of the terms of this contract shall be valid unless made in writing and signed by the parties hereto, and no oral understanding or agreement not incorporated herein, shall be binding on any of the parties hereto.

7. The consideration to be paid Contractor, as provided herein, shall be in compensation for all of Contractor's expenses incurred in the performance hereof, including travel and per diem, unless otherwise expressly so provided.

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1. Article II, DEFINITIONS, is amended by adding a new Section I, Catastrophic Coverage Limitation, to read:

   I. Catastrophic Coverage Limitation means the date beyond which Contractor is not at risk, as determined by the Director, to provide or make reimbursement for illness of or injury to beneficiaries which results from or is greatly aggravated by a catastrophic occurrence or disaster, including, but not limited to, an act of war, declared or undeclared, and which occurs subsequent to enrollment.

2. Article II, DEFINITIONS, is amended by relettering old Sections I through LL as new Sections J through MM.

3. Article II, DEFINITIONS, relettered Section P, Covered Services, is amended to read:

   P. Covered Services means Medical Case Management and those services set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301, and Title 17, CCR, Chapter 4, Subchapter 13, Article 4, beginning with Section 6840. Covered Services do not include:

      1. Services for major organ transplants as specified in Section 6.7.2.1, Major Organ Transplants.

      2. Long term care services as specified in Section 6.7.2.3, Long Term Care, (LTC).

      3. Home and community based services (HCBS) as specified in Sections 6.7.2.2, Waiver Programs, and 6.7.3.8, Department of Developmental Services Administered Medicaid Home and Community Based Services Waiver. HCBS do not include any service that is available as an EPSDT service, including EPSDT supplemental services, as described in Title 22, CCR, Sections 51184, 51340 and 51340.1. EPSDT supplemental services are covered under this Contract, as specified in Article VI, Section 6.7.4.4, Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Supplemental Services, Including Case Management Services.

      4. California Children Services (CCS) as specified in Section 6.7.3.2, CCS Services.

      5. Mental health services as specified in Section 6.7.3.3, Mental Health.

6. Alcohol and drug treatment services and outpatient heroin detoxification as specified in Section 6.7.3.4, Alcohol and Drug Treatment Services.

7. Fabrication of optical lenses as specified in Section 6.7.3.6, Vision Care - Lenses.

8. Directly observed therapy for tuberculosis as specified in Section 6.7.3.7, Directly Observed Therapy (DOT) for Treatment of Tuberculosis.

9. Dental services as specified in Title 22, CCR, Section 51307 and EPSDT supplemental dental services as described in Title 22, CCR, Section 51340.1(a). However, Contractor is responsible for all Covered Services as specified in Article VI, Section 6.7.3.5, Dental.

10. Acupuncture services as specified in Title 22, CCR, Section 51308.5.

11. Chiropractic services as specified in Title 22, CCR, Section 51308.

12. Prayer or spiritual healing as specified in Title 22, CCR, Section 51312.

13. Local Education Agency (LEA) assessment services as specified in Title 22, CCR, Section 51360(b)(1) provided to a Member who qualifies for LEA services based on Title 22, CCR, Section 51190.1(a).

14. Any LEA services as specified in Title 22, CCR, Section 51360 provided pursuant to an Individualized Education Plan (IEP) as set forth in Education Code, Section 56340 et seq. or an Individualized Family Service Plan (IFSP) as set forth in Government Code Section 95020, or LEA services provided under an Individualized Health and Support Plan (IHSP), as described in Title 22, CCR, Section 51360.

15. Laboratory services provided under the State serum alphafetoprotein- testing program administered by the Genetic Disease Branch of DHS.

16. Adult Day Health Care.

17. Targeted case management services as specified in Title 22, CCR, Sections 51185(h) and 51351, and as described in Article VI, Section 6.5.10.7, Targeted Case Management Services.

18. Childhood lead poisoning case management provided by County health departments.

19. HIV and AIDS drugs listed in Attachment II (consisting of one page), and HIV and AIDS drugs classified as Nucleoside Analogs, Protease Inhibitors, and Non-Nucleoside Reverse Transcriptase Inhibitors, approved by the federal Food and Drug Administration (FDA) after July 1, 1997.

4. Article II, DEFINITIONS, relettered Section Y, Eligible Beneficiary, is amended to read:

Y. Eligible Beneficiary means any Medi-Cal beneficiary who is residing in Contractor's Service Area with one of the following aid codes: CalWORKS/Public Assistance Family - aid codes 30, 32, 3G, 33, 3H, 35, 38, 39, 3A, 3C, 40, 42, 54, 59, 3P, 3R, 3N, 3U, 7X; 3E, 3L, 3M; Medically Needy Family - aid code 34; Public Assistance Aged - aid codes 10, 16, 18; Medically Needy Aged - aid code 14; Public Assistance Blind - aid codes 20, 26, 28, 6A; Medically Needy Blind - aid code 24; Public Assistance Disabled - aid codes 36, 60, 66, 68, 6C, 6N, 6P, 6R; Medically Needy Disabled - aid code 64; Medically Indigent Child - aid codes 03, 04, 45, 4C, 4K, 5K, 82; Medically Indigent Adult - aid code 86; and Refugees - aid codes 01, 0A, 02, and 08, with the following exclusions:

1. Individuals who have been approved by the Medi-Cal Field Office or the California Children Services Program for bone marrow, heart, heart-lung, liver, lung, combined liver and kidney, or combined liver and small bowel transplants.

2. Individuals who elect and are accepted to participate in the following Medi-Cal waiver programs: In-Home Medical Care Waiver Program, the Skilled Nursing Facility Waiver Program, the Model Waiver Program, the Acquired Immune Deficiency (AIDS) and AIDS Related Conditions Waiver Program, and the Multipurpose Senior Services Waiver Program.

3. Individuals determined by the Medi-Cal Field Office to be in need of long term care and residing in a Skilled Nursing Facility (SNF) for 30 days past the month of admission.

4. Individuals who have commercial or Medicare HMO coverage, unless the Medicare HMO is a provider under this Contract and DHS has agreed, as a term of the HMO's Contract, that these individuals may be enrolled, and DHS and the Medicare HMO have negotiated an appropriate rate for these individuals. Individuals with Medicare fee-for-service coverage are not excluded from enrolling under this Contract.

5. Article II, DEFINITIONS, relettered Section Z, Emergency Conditions, is amended to read:

Z. Emergency Medical Condition means a medical condition which is manifested by acute symptoms of sufficient severity (including severe pain), such that a prudent lay person, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. placing the health of the individual (or, in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

2. serious impairment to bodily function, or

3. serious dysfunction of any bodily organ or part.

6. Article II, DEFINITIONS, relettered Section AA, Emergency Services, is amended to read:

AA. Emergency Services means those health services needed to evaluate or stabilize an Emergency Medical Condition.

7. Article II, DEFINITIONS, relettered Section HH, Fee-For-Service Mental Health Services (FFS/MC), is amended to read:

HH. Fee-For-Service Medi-Cal Mental Health Services (FFS/MC) means the mental health services covered through Fee-For-Service Medi-Cal which include outpatient services and acute care inpatient services. These services are provided through Primary Care Physicians as well as psychiatrists and psychologists.

8. Article II, DEFINITIONS, relettered Section II, Financial Security, is amended to read:

   II. Financial Performance Guarantee means cash or cash equivalents which are immediately redeemable upon demand by DHS, in an amount determined by DHS, which shall not be less than one full month's capitation.

9. Article II, DEFINITIONS, is amended by adding a new Section NN, Health Plan Employer Data and Information Set, to read:

   NN. Health Plan Employer Data and Information Set (HEDIS) means the set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA), a not-for-profit organization. HEDIS is designed to ensure that the public has the information it needs to reliably compare the performance of managed health care plans.

10. Article II, DEFINITIONS, is amended by relettering old Sections MM through K2 as new Sections OO through M2.

11. Article II, DEFINITIONS, relettered Section QQ, Joint Commission on Accreditation of Hospitals (JCAHCO), is amended to read:

   QQ. Joint Commission on the Accreditation of Health Care Organizations (JCAHCO) means the organization composed of representatives of the American Hospital Association, the American Medical Association, the American College of Physicians, the American College of Surgeons, and the American Dental Association. JCAHCO provides health care accreditation and related services that support performance improvement in health care organizations.

12. Article II, DEFINITIONS, relettered Section B1, Minor Consent Services, is amended to read:

   B1. Minor Consent Services means those Covered Services of a sensitive nature which minors do not need parental consent to access related to:

      1. Sexual assault, including rape.

      2. Drug or alcohol abuse for children 12 years of age or older.

      3. Pregnancy.

4. Family planning.

5. Sexually transmitted diseases (STDs), designated by the Director, in children 12 years of age or older.

6. Outpatient mental health care for children 12 years of age or older who are mature enough to participate intelligently and where either (1) there is a danger of serious physical or mental harm to the minor or others or (2) the children are the alleged victims of incest or child abuse.

State law provides minors the right to obtain an abortion without parental consent.

13. Article II, DEFINITIONS, relettered Section P1, Primary Care Provider, is amended to read:

P1. Primary Care Provider means a person responsible for supervising, coordinating, and providing initial and Primary Care to Members; for initiating referrals and for maintaining the continuity of Member care. A Primary Care Provider may be a Primary Care Physician or Non-Physician Medical Practitioner.

14. Article II, DEFINITIONS, relettered Section X1, Sensitive Services, is amended to read:

X1. Sensitive Services means those services related to:

1. Family planning.

2. Sexually transmitted diseases (STDs).

3. Abortion.

4. HIV testing.

15. Article II, DEFINITIONS, relettered Section B2, Short-Doyle Medi-Cal Mental Health Services (SD/MC), is amended to read:

B2. Short-Doyle Medi-Cal Mental Health Services (SD/MC) means those services defined in Title 22, CCR, Section 51341. SD/MC Mental Health Services include: crisis intervention, crisis stabilization, inpatient hospital services, crisis residential treatment case management, adult residential treatment, day treatment intensive, rehabilitation, outpatient therapy, medication and support services.

16. Article II, DEFINITIONS, relettered Section J2, Third Party Liability (TPL), is amended to read:

    J2. Third Party Tort Liability (TPTL) means the responsibility of an individual or entity other than Contractor or the Member for the payment of claims for injuries or trauma sustained by a Member. This responsibility may be contractual, a legal obligation, or as a result of, or the fault or negligence of, third parties (e.g., auto accidents or other personal injury casualty claims or Workers' Compensation appeals).

17. Article II, DEFINITIONS, is amended by adding a new subsection N2 to read:

    N2. Physician Incentive Plan means any compensation arrangement between Contractor and a Physician or a Physician group that may directly or indirectly have the effect of reducing or limiting services provided to Members under this Contract.

18. Article II, DEFINITIONS, is amended by adding a new subsection O2 to read:

    O2. Rural Health Clinic (RHC) means an entity defined in Title 22, CCR, Section 51115.5.

19. Article II, DEFINITIONS, is amended by adding a new subsection P2 to read:

    P2. Beneficiary Assignment means the act of DHS or DHS' enrollment contractor of notifying a beneficiary in writing of the health plan in which the beneficiary shall be enrolled if the beneficiary fails to timely choose a health plan. If, at any time, the beneficiary notifies DHS or DHS' enrollment contractor of the beneficiaries health plan choice, such choice shall override the beneficiary assignment and be effective as provided in Article III, Section 3.23.3, Coverage.

20. Article II, DEFINITIONS, is amended by adding a new subsection Q2 to read:

    Q2. AIDS Beneficiary means a Member for whom a Diagnosis of Acquired Immunodeficiency Syndrome (AIDS) has been made by a treating Physician.

21. Article II, DEFINITIONS, is amended by adding a new subsection R2 to read:

R2. Diagnosis of AIDS means a clinical diagnosis of AIDS that meets the most recent communicable disease surveillance case definition of AIDS established by the federal Centers for Disease Control and Prevention (CDC), United States Department of Health and Human Services and published in the Morbidity and Mortality Weekly Report (MMWR) or its supplements, in effect for the month in which the clinical diagnosis is made.

22. Article II, DEFINITIONS, is amended by adding a new subsection S2 to read:

S2. Other Healthcare Coverage Sources (OHCS) means the responsibility of an individual or entity, other than Contractor or the Member, for the payment of the reasonable value of all or part of the healthcare benefits provided to a Member. Such OHCS may originate under any other State, federal, or local medical care program or under other contractual or legal entitlement, including, but not limited to, a private group or indemnification program. This responsibility may result from a health insurance policy or other contractual agreement or legal obligation, excluding tort liability.

23. Article II, DEFINITIONS, is amended by adding a new subsection T2 to read:

T2. Cost Avoid means Contractor requires a provider to bill all liable third parties and receive payment or proof of denial of coverage from such third parties prior to Contractor paying the provider for the services rendered.

24. Article II, DEFINITIONS, is amended by adding a new subsection U2 to read:

U2. Post-Payment Recovery means Contractor pays the provider for the services rendered and then uses all reasonable efforts to recover the cost of the services from all liable third parties.

25. Article II, DEFINITIONS, is amended by adding a new subsection V2 to read:

V2. Word Usage. Unless the context of this Contract clearly requires otherwise, (a) the plural and singular numbers shall each be deemed to include the other; (b) the masculine, feminine, and neuter genders shall each be deemed to include the others; (c) "shall," "will," "must," or "agrees" are mandatory, and "may" is permissive; (d) "or" is not exclusive; and (e) "includes" and "including" are not limiting.

26. Article II, DEFINITIONS, is amended by adding a new section W2 to read:

W2. Specialty Mental Health Provider means a person or entity who is licensed, certified or otherwise recognized or authorized under State law governing the healing arts to provide Specialty Mental Health Services and who meets the standards for participation in the Medi-Cal program. Specialty Mental Health Providers include clinics, hospital outpatient departments, certified residential treatment facilities, skilled nursing facilities, psychiatric health facilities, hospitals, and licensed mental health professionals, including psychiatrists, psychologists, licensed clinical social workers, marriage, family and child counselors, and registered nurses authorized to provide Specialty Mental Health Services.

27. Article II, DEFINITIONS, is amended by adding a new section X2 to read:

X2. Specialty Mental Health Service means:

1. Rehabilitative services, which includes mental health services, medication support services, day treatment intensive, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services, and psychiatric health facility services;

2. Psychiatric inpatient hospital services;

3. Targeted Case Management;

4. Psychiatrist services;

5. Psychologist services; and

6. EPSDT supplemental specialty mental health services.

28. Article III, GENERAL TERMS AND CONDITIONS, is amended by adding new Sections 3.1 and 3.2 to read:

3.1 INTERPRETATION OF CONTRACT

If it is necessary to interpret this Contract, all applicable laws may be used as aids in interpreting the Contract. However, the parties agree that any such applicable laws shall not be interpreted to create contractual obligations upon DHS or Contractor, unless such applicable laws are expressly incorporated into this Contract in some section other than this Section 3.1, Interpretation of Contract. Except for Section 3.19, Sanctions and Section 3.20, Liquidated Damages Provision, the parties agree that any remedies for DHS' or Contractor's non-compliance with laws not expressly incorporated into this Contract, or any covenants implied to be part of this Contract, shall not include money damages, but may include equitable remedies such as injunctive relief or specific performance. In the event any provision of this Contract is held invalid by a court, the remainder of this Contract shall not be affected. This Contract is the product of mutual negotiation, and if any ambiguities should arise in the interpretation of this Contract, both parties shall be deemed authors of this Contract.

3.2 ENTIRE AGREEMENT

This written Contract and any amendments shall constitute the entire agreement between the parties. No oral representations shall be binding on either party unless such representations are reduced to writing and made an amendment to the Contract.

29. Article III, GENERAL TERMS AND CONDITIONS, is amended by renumbering old Section 3.1, Delegation of Authority, as Section 3.3 and amending paragraph three to read:

Contractor's Representative shall be designated in writing by Contractor. Such designation shall be submitted to the Contracting Officer in accordance with Section 3.5, Authority of the State.

30. Article III, GENERAL TERMS AND CONDITIONS, is amended by deleting old Section 3.2, Governing Authorities, and replacing it with a new Section 3.4, Changes in Statutes or Regulations, to read:

    3.4 CHANGES IN STATUTES OR REGULATIONS

    The parties recognize that during the life of this Contract, the Medi-Cal Managed Care Program shall be a dynamic program requiring numerous changes to its operations and

    that the scope and complexity of these changes shall vary widely over the life of the Contract. The parties agree that the development of a system that has the capability to implement such changes in an orderly and timely manner is of considerable importance.

    Any provision of this Contract which is in conflict with current or future applicable federal or State laws or regulations is hereby amended to conform to the provisions of those laws and regulations. Such amendment of the Contract shall be effective on the effective date of the statutes or regulations necessitating it, and shall be binding on the parties even though such amendment may not have been reduced to writing and formally agreed upon and executed by the parties.

    Such amendment shall constitute grounds for termination of this Contract in accordance with the procedures and provisions of Section 3.18.2, Termination - Contractor. The parties shall be bound by the terms of the amendment until the effective date of the termination.

31. Article III, GENERAL TERMS AND CONDITIONS, is amended by renumbering old Sections 3.3 through 3.9, as Sections 3.5 through 3.11.

32. Article III, GENERAL TERMS AND CONDITIONS, renumbered Section 3.7, Compliance with Protocols, sentence one, is amended to read:

    Contractor shall develop the protocols and procedures specified in this Contract and shall comply with them within 30 days of their approval by DHS.

33. Article III, GENERAL TERMS AND CONDITIONS, is amended by deleting old Section 3.10, Membership Diversity.

34. Article III, GENERAL TERMS AND CONDITIONS, is amended by renumbering old Sections 3.11 through 3.43 as Sections 3.12 through 3.44.

35. Article III, GENERAL TERMS AND CONDITIONS, renumbered Section 3.12, Inspection Rights, is amended to read:

3.12 INSPECTION RIGHTS

Through the end of the records retention period specified in Section 3.32.2, Records Retention, Contractor shall allow DHS, DHHS, the Comptroller General of the United States, Department of Justice (DOJ) Bureau of Medi-Cal Fraud, Department of Corporations (DOC), and other authorized State agencies, or their duly authorized representatives, including DHS' external quality review organization contractor, to inspect, monitor or otherwise evaluate the quality, appropriateness, and timeliness of services performed under this Contract, and to inspect, evaluate, and audit any and all books, records, and Facilities maintained by Contractor and subcontractors pertaining to these services at any time during normal business hours.

Books and records include, but are not limited to, all physical records originated or prepared pursuant to the performance under this Contract, including working papers, reports, financial records, and books of account, Medical Records, prescription files, laboratory results, Subcontracts, information systems and procedures, and any other documentation pertaining to medical and non-medical services rendered to Members. Upon request, through the end of the records retention period specified in Section 3.32.2, Records Retention, Contractor shall furnish any record, or copy of it, to DHS or any other entity listed in this section, at Contractor's sole expense.

36. Article III, GENERAL TERMS AND CONDITIONS, renumbered Section 3.15, Term, paragraph two, is amended to read:

The term of the Contract consists of the following three periods: 1) The Implementation Period shall extend from March 1, 1996 to June 1,1996; 2) The Operations Period shall extend from June 1, 1996 to March 1,2001, subject to the termination provisions of Sections 3.18, Termination, and 3.19, Sanctions, and subject to the limitation provisions of Article V, Payment Provisions, Section 5.2, Amounts Payable; and 3) The Turnover/Phaseout Period shall extend for six (6) months from the end of the Operations Period, subject to the provisions of Section 3.16, Contract Extension, in which case the Turnover/Phaseout Period shall apply to the six (6) month period beginning the first day after the end of the Operations Period, as extended.

37. Article III, GENERAL TERMS AND CONDITIONS, renumbered Section 3.17, Turnover and Phaseout Requirements, paragraph one, is amended to read:

    DHS shall retain an amount equal to 10% or one million dollars ($1,000,000), whichever is greater unless provided otherwise by the Financial Performance Guarantee, from the capitation payment of the last month of the Operations Period until all activities required during the Turnover and Phaseout Period are fully completed to the satisfaction of DHS, in it sole discretion.

38. Article III, GENERAL TERMS AND CONDITIONS, renumbered Section 3.18.1, Termination - State or Director, paragraph two, is amended to read:

    Notification shall be given at least nine (9) months prior to the effective date of termination, except in cases where the Director determines the health and welfare of Members is jeopardized by continuation of this Contract, in which case the Contract shall be immediately terminated. Notification shall state the effective date of, and the reason for the termination. DHS and Contractor may negotiate an earlier termination date.

39. Article III, GENERAL TERMS AND CONDITIONS, renumbered Section 3.18.2, Termination - Contractor, is amended to read:

    3.18.2 TERMINATION - CONTRACTOR

    If mutual agreement between DHS and Contractor cannot be attained on capitation rates for rate years subsequent to September 30,1997, Contractor shall retain the right to terminate the Contract, no earlier than September 30,1998, by giving at least nine (9) months written notice to DHS to that effect. The effective date of any termination under this section shall be September 30.

    Grounds under which Contractor may terminate this Contract are limited to: (1) Unwillingness to accept the capitation rates determined by DHS, or if DHS decides to negotiate rates, failure to reach mutual agreement on rates; or (2) When a change in contractual obligations is created by a State or federal change in the Medi-Cal program, or a lawsuit, that substantially alters the financial assumptions and conditions under which Contractor entered into this Contract, such that Contractor can demonstrate to the satisfaction of DHS that it cannot remain financially solvent through the term of the Contract.

If Contractor invokes ground number 2, Contractor shall submit a detailed written financial analysis to DHS supporting its conclusions that it cannot remain financially solvent. At the request of DHS, Contractor shall submit or otherwise make conveniently available to DHS, all of Contractor's financial work papers, financial reports, financial books and other records, bank statements, computer records, and any other information required by DHS to evaluate Contractor's financial analysis.

Based on the above two grounds, Contractor may terminate the Contract, no earlier than September 30, 1998, by giving at least nine (9) months written notice to DHS to that effect. The effective date of any termination under this section shall be September 30.

DHS and Contractor may negotiate an earlier termination date if Contractor can demonstrate to the satisfaction of DHS that it cannot remain financially solvent until the termination date that would otherwise be established under this section. Termination under these circumstances shall not relieve Contractor from performing the Turnover and Phaseout activities, as described in Section 3.17.

40. Article III, GENERAL TERMS AND CONDITIONS, renumbered Section 3.18.3, Mandatory Termination, paragraph 2, is amended to read:

Under these circumstances, termination of the Contract shall be effective on the last day of the month in which the Secretary, DHHS, or DOC makes such determination, provided that DHS provides Contractor with at least 60 days notice of termination. The termination of this Contract shall be effective on the last day of the second full month from the date of the notice of termination. Contractor agrees that 60 days notice is reasonable. Termination under this section does not relieve Contractor of its obligations under the Turnover and Phaseout Requirements, Sections 3.17 through 3.17.4, except that these requirements may be performed after Contract termination.

41. Article III, GENERAL TERMS AND CONDITIONS, renumbered Section 3.19, Sanctions, is amended to read:

3.19 SANCTIONS

In the event DHS finds Contractor non-compliant with any provisions of this Contract, applicable statutes or regulations, or for good cause shown, DHS may impose sanctions provided in Welfare and Institutions Code, Section 14304 and Title 22, CCR, Section 53872. Good cause includes, but is not limited to, three repeated and uncorrected findings of serious deficiencies that have the potential to endanger patient care identified in the medical audits conducted by DHS.

If required by DHS, Contractor shall ensure subcontractors cease specified activities which may include, but are not limited to, referrals, assignment of beneficiaries, and reporting, until DHS determines that Contractor is again in compliance.

42. Article III, GENERAL TERMS AND CONDITIONS, renumbered Section 3.20.1, General, is amended to read:

3.20.1 GENERAL

It is agreed by the State and Contractor that:

A. If Contractor does not provide or perform the requirements of this Contract or applicable laws and regulations, damage to the State shall result;

B. Proving such damages shall be costly, difficult, and time-consuming;

C. Should the State choose to impose liquidated damages, Contractor shall pay the State those damages for not providing or performing the specified requirements;

D. Additional damages may occur in specified areas by prolonged periods in which Contractor does not provide or perform requirements;

E. The damage figures listed below represent a good faith effort to quantify the range of harm that could reasonably be anticipated at the time of the making of the Contract;

F. DHS may, at its discretion, offset liquidated damages from capitation payments owed to Contractor;

G. Imposition of liquidated damages as specified in Sections 3.20.2, Liquidated Damages for Violation of Contract Terms Regarding the Implementation Period, 3.20.3, Liquidated Damages for Violation of Contract Terms or Regulations Regarding the Operations Period, and 3.20.4, Annual Medical Reviews, shall follow the administrative processes described below;

H. DHS shall provide Contractor with written notice specifying Contractor requirement(s), contained in the Contract or as required by federal and State law or regulation, not provided or performed;

I. During the Implementation Period, Contractor shall submit or complete the outstanding requirement(s) specified in the written notice within five (5) State working days from the date of the notice, unless, subject to the Contracting Officer's written approval, Contractor submits a written request for an extension. The request must include the following: the requirement(s) requiring an extension; the reason for the delay; and the proposed date of the submission of the requirement.

J. During the Implementation Period, if Contractor has not performed or completed an Implementation Period requirement or secured an extension for the submission of the outstanding requirement, DHS may impose liquidated damages for the amount specified in Section 3.20.2, Liquidated Damages for Violation of Contract Terms Regarding the Implementation Period.

K. During the Operations Period, Contractor shall demonstrate the provision or performance of Contractor's requirement(s) specified in the written notice within a thirty (30) calendar day Corrective Action period from the date of the notice, unless within five (5) days from the end of the Corrective Action period a request for an extension is submitted to the Contracting Officer. If Contractor has not demonstrated the provision or performance of Contractor's requirement(s) specified in the written notice by the end of the Corrective Action period, DHS may impose liquidated damages for each day the specified Contractor's requirement is not performed or provided for, in the amount specified in Section 3.20.3, Liquidated Damages for Violation of Contract Terms or Regulations Regarding the Operations Period.

L. During the Operations Period, if Contractor has not performed or provided Contractor's requirement(s) specified in the written notice or secured the written approval for an extension, after thirty (30) days from the first day of the imposition of liquidated damages, DHS shall notify Contractor in writing of the increase of the liquidated damages to the amount specified in Section 3.20.3, Liquidated Damages for Violation of Contract Terms or Regulations Regarding the Operations Period.

Nothing in this provision shall be construed as relieving Contractor from performing any other Contract duty not listed herein, nor is the State's right to enforce or to seek other remedies for failure to perform any other Contract duty hereby diminished.

43. Article III, GENERAL TERMS AND CONDITIONS, renumbered Section 3.20.4, Annual Medical Reviews, paragraph one, sentence two, is amended to read:

    If, after notice, Contractor does not correct the deficiency to the satisfaction of DHS within thirty (30) days, or longer if authorized by DHS in writing, DHS may impose an additional liquidated damages of $5,000 per day per major uncorrected deficiency as determined by DHS medical review staff.

44. Article III, GENERAL TERMS AND CONDITIONS, renumbered Section 3.22.3, Contracting Officer's Decision, is amended to read:

    3.22.3 CONTRACTING OFFICER'S OR ALTERNATE DISPUTE OFFICER'S DECISION

    Pursuant to a request by Contractor, the Contracting Officer may provide for a dispute to be decided by an alternate dispute officer designated by DHS, who is not the Contracting Officer and is not directly involved in the Medi-Cal Managed Care Program. Any disputes concerning performance of this Contract shall be decided by the Contracting Officer or the alternate dispute officer in a written decision stating the factual basis for the decision. Within thirty (30) days of receipt of a Notification of Dispute, the Contracting Officer or the alternate dispute officer shall either render a decision or shall request from Contractor, which in the opinion of the Contracting Officer or alternate dispute officer is sufficient to allow the rendering of a decision. Within thirty (30) days of receipt of the additional substantiating documentation requested, a decision shall be rendered. A copy of the decision shall be served on Contractor.

    The Contracting Officer's or alternate dispute officer's decision shall:

    A. Find in favor of Contractor, in which case the Contracting Officer or alternate dispute officer may:

        1. Countermand the earlier conduct which caused Contractor to file a dispute; or

        2. Reaffirm the conduct and, if there is a cost impact sufficient to constitute a change in obligations pursuant to the payment provisions contained in Article V, direct DHS to comply with that section.

    B. Deny Contractor's dispute and, where necessary, direct the manner of future performance; or

C. Request additional substantiating documentation in the event the information in Contractor's notification is inadequate to permit a decision to be made under A. or B. above, and shall advise Contractor as to what additional information is required, and establish how that information shall be furnished. Contractor shall have thirty (30) days to respond to the Contracting Officer's or alternate dispute officer's request for further information. Upon receipt of this additional requested information, the Contracting Officer or alternate dispute officer shall have thirty (30) days to respond with a decision. Failure to supply additional information required by the Contracting Officer or alternate dispute officer within the time period specified above shall constitute waiver by Contractor of all claims in accordance with Section 3.22.6, Waiver of Claims.

45. Article III, GENERAL TERMS AND CONDITIONS, is amended by adding a new Section 3.22.4, to read:

3.22.4 APPEAL OF CONTRACTING OFFICER'S OR ALTERNATE DISPUTE OFFICER'S DECISION

Contractor shall have thirty (30) calendar days following the receipt of the decision to file an appeal of the decision to the Director. All appeals shall be governed by Health and Safety Code Section 100171, except for those provisions of Section 100171(d)(1) relating to accusations, statements of issues, statement to respondent, and notice of defense. All appeals shall be in writing and shall be filed with DHS' Office of Administrative Hearings and Appeals. An appeal shall be deemed filed on the date it is received by the Office of Administrative Hearings and Appeals. An appeal shall specifically set forth each issue in dispute, and include Contractor's contentions as to those issues. However, Contractor's appeal shall be limited to those issues raised in its Notice of Dispute filed pursuant to Section 3.22.2, Notification of Dispute. Failure to timely appeal the decision shall constitute a waiver by Contractor of all claims arising out of that conduct, in accordance with Section 3.22.6, Waiver of Claims. Contractor shall exhaust all procedures provided for in Section 3.22, Disputes and Appeals, prior to initiating any other action to enforce this Contract.

46. Article III, GENERAL TERMS AND CONDITIONS, old Section 3.21.4, Contractor Duty to Perform, is amended to read:

3.22.5 CONTRACTOR DUTY TO PERFORM

Pending final determination of any dispute hereunder, Contractor shall proceed diligently with the performance of this Contract and in accordance with the Contracting Officer's or alternate dispute officer's decision.

If, pursuant to an appeal under Section 3.22.4, Appeal of Contracting Officer's or Alternate Dispute Officer's Decision, the Contracting Officer's or alternate dispute officer's decision is reversed, the effect of the decision pursuant to Section 3.22.4 shall be retroactive to the date of the Contracting Officer's or alternate dispute officer's decision, and Contractor shall promptly receive any benefits of such decision. DHS shall not pay any interest on any amounts paid pursuant to a Contracting Officer's or alternate dispute officer's decision or any appeal of such decision.

47. Article III, GENERAL TERMS AND CONDITIONS, old Section 3.21.5, Waiver of Claims, is amended to read:

3.22.6 WAIVER OF CLAIMS

If Contractor fails to submit a Notification of Dispute, supporting and substantiating documentation, any additionally required information, or an appeal of the Contracting Officer's or alternate dispute officer's decision, in the manner and within the time specified in the Disputes and Appeals sections, that failure shall constitute a waiver by Contractor of all claims arising out of that conduct, whether direct or consequential in nature.

48. Article III, GENERAL TERMS AND CONDITIONS, renumbered Section 3.23.1, Enrollment - General, is amended to read:

3.23.1 ENROLLMENT - GENERAL

Eligible Beneficiaries residing within the Service Area of Contractor may be enrolled at any time during the term of this Contract. Eligible Beneficiaries shall be accepted by Contractor up to the limits imposed in Section 3.23.2, Enrollment Totals, and without regard to physical or mental condition, age, sex, race, religion, creed, color, national origin, marital status, sexual orientation or ancestry.

49. Article III, GENERAL TERMS AND CONDITIONS, renumbered Section 3.23.3, Coverage, is amended to read:

3.23.3 COVERAGE

Member coverage shall begin at 12:01 a.m. on the first day of the calendar month for which the Eligible Beneficiary's name is added to the approved list of Members furnished by DHS to Contractor. The term of membership shall continue indefinitely unless this Contract expires, is terminated, or the Member is disenrolled under the conditions described in Section 3.23.5, Disenrollment.

50. Article III, GENERAL TERMS AND CONDITIONS, renumbered Section 3.23.5, Disenrollment, is amended to read:

3.23.5 DISENROLLMENT

The enrollment contractor shall process a Member Disenrollment under the following conditions, subject to approval by DHS, in accordance with the provisions of Title 22, CCR, Section 53891:

A. Disenrollment of a Member is mandatory when:

1. The Member requests Disenrollment, subject to any lock-in restrictions on Disenrollment under the federal lock-in option, if applicable.

2. The Member's eligibility for Enrollment with Contractor is terminated or eligibility for Medi-Cal is ended, including the death of the Member.

3. Enrollment was in violation of Title 22, CCR, Section 53891 (a)(2), or requirements of this Contract regarding Marketing, and DHS or Member requests Disenrollment.

4. Disenrollment is requested in accordance with Welfare and Institutions Code, Sections 14303.1 or 14303.2.

5. There is a change of a Member's place of residence to outside Contractor's Service Area.

6. It is determined that the Member is enrolled as a commercial or Medicare member of an HMO other than Contractor.

7. Disenrollment is based on the circumstances described in Article VI, Section 6.7.2, Excluded Services: Circumstances Under Which Member Disenrolled.

Such Disenrollment shall become effective on the first day of the second month following receipt by DHS of all documentation necessary, as determined by DHS, to process the Disenrollment, provided Disenrollment was requested at least 30 days prior to that date, except for Disenrollments pursuant to Article VI, Section 6.7.2.1, Major Organ Transplants, for which Disenrollment shall be effective the beginning of the month in which the transplant is approved.

B. Contractor shall recommend to DHS the Disenrollment of any Member in the event of a breakdown in the "Contractor/Member relationship" which makes it impossible for Contractor's providers to render services adequately to a Member. Except in cases of violent behavior or fraud, Contractor shall make significant efforts to resolve the problem with the Member through avenues such as reassignment of Primary Care Physician, education, or referral to services (such as mental health or substance abuse programs), before requesting a Contractor-initiated Disenrollment. In cases of Contractor-initiated Disenrollment of a Member, Contractor must submit to DHS a written request with supporting documentation for Disenrollment based on the breakdown of the "Contractor/Member relationship." Contractor-initiated disenrollments must be prior approved by DHS and shall be considered only under the following circumstances:

1. Member is repeatedly verbally abusive to Contractor providers, ancillary or administrative staff, subcontractor staff, or to other plan Members.

2. Member physically assaults a Contractor provider or staff person, subcontractor staff person, or other Member, or threatens another individual with a weapon on Contractor premises. In this instance, Contractor or subcontractor shall file a police report and file charges against the Member.

3. Member is disruptive to Contractor operations, in general.

4. Member habitually uses providers not affiliated with Contractor for non-Emergency Services without required authorizations (causing Contractor to be subjected to repeated provider demands for payment for those services or other demonstrable degradation in Contractor's relations with community providers).

5. Member has allowed the fraudulent use of Medi-Cal coverage under the plan, which includes allowing others to use the Member's plan membership card to receive services from Contractor.

C. A Member's failure to follow prescribed treatment (including failure to keep established medical appointments) shall not, in and of itself, be good cause for the approval by DHS of a Contractor-initiated Disenrollment request unless Contractor can demonstrate to DHS that, as a result of the failure, Contractor is exposed to a substantially greater and unforeseeable risk than that otherwise contemplated under the Contract and rate-setting assumptions.

D. The problem resolution attempted prior to a Contractor-initiated Disenrollment described in subsection B, must be documented by Contractor. A formal procedure for Contractor-initiated Disenrollments shall be established by Contractor and approved by DHS. As part of the procedure, the Member shall be notified in writing by Contractor of the intent to disenroll the Member for cause and allowed a period of no less that twenty (20) days to respond to the proposed action.

1. Contractor must submit a written request for Disenrollment and the documentation supporting the request to DHS for approval. The supporting documentation must establish the pattern of behavior and Contractor's efforts to resolve the problem. DHS shall review the request and render a decision in writing within ten(10) State working days of receipt of a Contractor request and necessary documentation. If the Contractor-initiated request for Disenrollment is approved by DHS, DHS shall submit the Disenrollment request to the enrollment contractor for processing. Contractor shall be notified by DHS of the decision, and if the request is granted, shall be notified by the enrollment contractor of the effective date of the Disenrollment. Contractor shall notify the Member of the Disenrollment for cause if DHS grants the Contractor-initiated request for Disenrollment.

2. Contractor shall continue to provide Covered Services to the Member until the effective date of the Disenrollment.

E. Except as provided in subsection A.7, Membership shall cease no later than midnight on the last day of the second calendar month after the Member's Disenrollment request and all required supporting documentation are received by DHS. On the first day after membership ceases, Contractor is relieved of all obligations to provide Covered Services to the Member under the terms of this Contract. Contractor agrees in turn to return to DHS any capitation payment forwarded to Contractor for persons no longer enrolled under this Contract.

F. Contractor shall implement and maintain procedures to ensure that all Members requesting Disenrollment or information regarding the Disenrollment process are immediately referred to the enrollment contractor.

51. Article III, GENERAL TERMS AND CONDITIONS, renumbered Section 3.25, Pharmaceutical Services and Prescribed Drugs, sentence one, is amended to read:

Contractor shall provide pharmaceutical services and prescribed drugs, either directly or through Subcontracts, in accordance with all laws and regulations regarding the provision of pharmaceutical services and prescription drugs to Medi-Cal beneficiaries, including, but not limited to, Title 22, CCR, Section 53854.

52. Article III, GENERAL TERMS AND CONDITIONS, renumbered Section 3.26, Facilities, is amended to read:

3.26 FACILITIES

Facilities used by Contractor for providing Covered Services shall comply with the provisions of Title 22, CCR, Section 53856.

53. Article III, GENERAL TERMS AND CONDITIONS, renumbered Section 3.28, Subcontracts, sentence two, is amended to read:

In doing so, Contractor shall meet the subcontracting requirements as stated in Title 22, CCR, Section 53867 and this Contract.

54. Article III, GENERAL TERMS AND CONDITIONS, renumbered Section 3.28.1, Knox-Keene and Regulations, is amended to read:

3.28.1 KNOX-KEENE AND REGULATIONS

All Subcontracts shall be in writing, and shall be entered into in accordance with the requirements of the Knox-Keene Health Care Services Plan Act of 1975, Health and Safety Code Section 1340 et seq.; Title 10, CCR, Section 1300 et seq.; W&I Code Section 14200 et seq.; Title 22, CCR, Section 53800 et seq.; and applicable federal and State laws and regulations.

55. Article III, GENERAL TERMS AND CONDITIONS, renumbered Section 3.28.2, Subcontract Requirements, Subsection D, is amended to read:

D. Subcontractor's agreement to assist Contractor in the transfer of care pursuant to Section 3.17.2, Turnover Requirements, in the event of Contract termination.

56. Article III, GENERAL TERMS AND CONDITIONS, is amended by adding a new subsection H, to renumbered Section 3.28.2, Subcontract Requirements, to read:

H. Subcontractor's agreement to timely gather, preserve and provide to DHS, any records in the Subcontractor's possession, in accordance with Section 3.45, Records Related to Recovery for Tobacco Related Illnesses.

57. Article III, GENERAL TERMS AND CONDITIONS, renumbered Section 3.28.3, Departmental Approval - Non-Federally Qualified HMOs, is amended to read:

3.28.3 DEPARTMENTAL APPROVAL - NON-FEDERALLY QUALIFIED HMOS

Except as provided in Section 3.28.6, Federally Qualified Health Centers/Rural Health Clinics, a provider or management Subcontract entered into by a Contractor which is not a federally qualified HMO shall become effective upon approval by DHS in writing, or by operation of law where DHS has acknowledged receipt of the proposed Subcontract, and has failed to approve or disapprove the proposed Subcontract within sixty (60) days of receipt. Within five (5) State working days of receipt, DHS shall acknowledge in writing the receipt of any material sent to DHS by Contractor for approval.

Subcontract amendments shall be submitted to DHS for prior approval at least thirty (30) days before the effective date of any proposed changes governing compensation, services, or term. Proposed changes which are neither approved or disapproved by DHS, shall become effective by operation of law 30 days after DHS has acknowledged receipt or upon the date specified in the Subcontract amendment, whichever is later.

58. Article III, GENERAL TERMS AND CONDITIONS, renumbered Section 3.28.4, Departmental Approval - Federally Qualified HMOs, is amended to read:

3.28.4 DEPARTMENTAL APPROVAL - FEDERALLY QUALIFIED HMOS

Except as provided in Section 3.28.6, Federally Qualified Health Centers/ Rural Health Clinics, Subcontracts entered into by a plan which is a federally qualified HMO shall be:

A. Exempt from prior approval by DHS.

B. Submitted to DHS upon request.

59. Article III, GENERAL TERMS AND CONDITIONS, renumbered Section 3.28.6, Federally Qualified Health Centers, is amended to read:

3.28.6 FEDERALLY QUALIFIED HEALTH CENTERS/RURAL HEALTH CLINICS

Contractor shall not enter into a Subcontract with a Federally Qualified Health Center (FQHC) or a Rural Health Clinic (RHC) unless DHS approves the provisions regarding rates, which shall be subject to the standard that they be reasonable, as determined by DHS, in relation to the services to be provided in accordance with Article VI, Section 6.6.21, FQHC and RHC Contracts. In Subcontracts where the FQHC or RHC has made the election to be reimbursed on a reasonable cost basis by the State, provisions shall be included that require the subcontractor to keep a record of the number of visits by plan Members separate from Fee-For-Service Medi-Cal beneficiaries, in addition to any other data reporting requirements of the Subcontract.

Subcontracts with FQHCs shall also meet Contract requirements of Article VI, Sections 6.6.20, FQHC Services, and 6.6.21, FQHC and RHC Contracts. Subcontracts with RHCs shall also meet Contract requirements of Article VI, Section 6.6.21.

In Subcontracts where a negotiated reimbursement rate is agreed to as total payment, a provision that such rate constitutes total payment shall be included in the Subcontract.

60. Article III, GENERAL TERMS AND CONDITIONS, renumbered Section 3.28.8, Disclosures, is amended to read:

3.28.8 DISCLOSURES

Each Subcontract shall contain at least the elements required by Section 3.28.2, Subcontract Requirements, and the following:

A. Full disclosure of the method and amount of compensation or other consideration to be received by the subcontractor from the plan.

B. Specification of the services to be provided by the subcontractor.

C. Specification that the Subcontract shall be governed by and construed in accordance with the contractual obligations of Contractor.

D. Specification that the Subcontract or Subcontract amendments shall become effective only as set forth in Sections 3.28.3, Departmental Approval - Non-Federally Qualified HMOs, or 3.28.4, Departmental Approval - Federally Qualified HMOs.

E. Specification of the term of the Subcontract including the beginning and ending dates as well as methods of extension, renegotiation and termination.

F. Subcontractor's agreement to submit reports as required by Contractor.

61. Article III, GENERAL TERMS AND CONDITIONS, renumbered Section 3.28.9, Payment, is amended to read:

3.28.9 PAYMENT

Contractor shall pay all claims submitted by subcontracting providers in accordance with this section, unless the subcontracting provider and Contractor have agreed in writing to an alternate payment schedule.

A. Contractor shall comply with Section 1932(f), Title XIX, Social Security Act (42 U.S.C. Section 1396u-2(f)), and Health and Safety Code, Section 1371, subject to the following:

1. Contractor shall pay or deny 90% of claims for payment submitted by providers for which no further written documentation or substantiation is required within 30 calendar days of receipt by Contractor. Written notice must be given to providers of contested claims within thirty (30) calendar days after receipt of the claim by Contractor. Such notice shall state the reason(s) for contesting the claim. Contractor agrees that failure to provide timely notification to a provider of a contested claim means that the claim is not being contested and is subject to the requirements for paying uncontested claims.

2. Contractor shall ensure that 100% of claims for payment submitted by providers for which no further written documentation or substantiation is required are paid or denied within forty-five (45) State working days after receipt.

B. Contractor shall maintain procedures for prepayment and postpayment claims review, including review of data related to provider, Member and Covered Services for which payment is claimed.

C. Contractor shall maintain sufficient claims processing/tracking/payment systems capability to: comply with applicable state and federal law, regulations and Contract requirements, determine the status of received claims, and calculate the estimate for incurred and unreported claims, as specified by Title 10, CCR, Sections 1300.77.1 and 1300.77.2.

62. Article III, GENERAL TERMS AND CONDITIONS, is amended by adding a new Section 3.28.10 to read:

3.28.10 ELECTRONIC BILLING CAPABILITY

No later than April 1, 1999, Contractor shall submit to DHS a written report detailing Contractor's actual or planned capability to accept provider claims electronically. The report shall describe Contractor's electronic capability for accepting claims from the following types of providers:

A. Pharmacy;

B. Hospital;

C. Physician, including Emergency room Physician; and

D. Allied health providers.

The report shall include a timetable for implementation of the necessary electronic capability for each type of provider claim that Contractor plans to install. For each type of provider claim that Contractor has no plans to accept electronically, the report shall include a supporting statement, which shall include a cost-benefit analysis, any infrastructure limitations, and any other circumstances that could preclude acceptance of those claims electronically. DHS shall submit any questions regarding Contractor's report within sixty (60) days of DHS' receipt of the report. Contractor shall respond to any questions from DHS within 60 (sixty) days after Contractor's receipt of the questions.

63. Article III, GENERAL TERMS AND CONDITIONS, is amended by adding a new Section 3.28.11 to read:

3.28.11 PHYSICIAN INCENTIVE PLAN REQUIREMENTS

Contractor may implement and maintain a Physician Incentive Plan only if:

A. No specific payment is made directly or indirectly under the incentive plan to a Physician or Physician group as an inducement to reduce or limit Medically Necessary Covered Services provided to an individual Member; and

B. The stop-loss protection (reinsurance), beneficiary survey, and disclosure requirements of 42 CFR 417.479 are met by Contractor.

64. Article III, GENERAL TERMS AND CONDITIONS, renumbered Section 3.33, Amendment of Contract, is amended to read:

3.33 AMENDMENT OF CONTRACT

Should either party during the life of this Contract desire a change in this Contract, that change shall be proposed in writing to the other party. The other party shall acknowledge receipt of the proposal within 10 days of receipt of the proposal. The party proposing any such change shall have the right to withdraw the proposal any time prior to acceptance or rejection by the other party. Any proposal shall set forth an explanation of the reason and basis for the proposed change and the text of the desired amendment to this Contract which would provide for the change. If the proposal is accepted, this Contract shall be amended to provide for the change mutually agreed to by the parties on the condition that the amendment is approved by DHHS, and the State Department of Finance, if necessary.

65. Article III, GENERAL TERMS AND CONDITIONS, renumbered Section 3.41, Recovery From Other Sources or Providers, is amended to read:

3.41 COST AVOIDANCE AND POST-PAYMENT RECOVERY OF OTHER HEALTH COVERAGE SOURCES

A. Contractor shall Cost Avoid or make a Post-Payment Recovery for the reasonable value of services paid for by Contractor and rendered to a Member whenever a Member's OHCS covers the same services, either fully or partially. However, in no event shall Contractor Cost Avoid or seek Post-Payment Recovery for the reasonable value of services from a TPTL action or make a claim against the estates of deceased Members.

B. All monies recovered by Contractor are retained by Contractor.

C. Contractor shall coordinate benefits with other coverage programs or entitlements, recognizing the OHCS as primary and the Medi-Cal program as the payor of last resort.

D. Cost Avoidance

1. If Contractor reimburses the provider on a fee-for-service basis, Contractor shall not pay claims for services provided to a Member whose Medi-Cal eligibility record indicates third party coverage, designated by a Other Health Coverage (OHC) code or Medicare coverage, without proof that the provider has first exhausted all sources of other payments. Contractor shall have written procedures implementing this requirement. Contractor shall submit these procedures to DHS for review and comment.

2. Proof of third party billing is not required prior to payment for services provided to Members with OHC codes A, M, X, Y, or Z.

E. Post-Payment Recovery

1. If Contractor reimburses the provider on a fee-for-service basis, Contractor shall pay the provider's claim and then seek to recover the cost of the claim by billing the liable third parties:

a. For services provided to Members with OHC codes A, M, X, Y, or Z;

b. For services defined by DHS as prenatal or preventive pediatric services; or

c. In child-support enforcement cases, identifiable by Contractor. If Contractor does not have access to sufficient information to determine whether or not the OHC coverage is the result of a child support enforcement case, Contractor shall follow the procedures for Cost Avoidance.

2. In instances where Contractor does not reimburse the provider on a fee-for-service basis, Contractor shall pay for services provided to a Member whose eligibility record indicates third party coverage, designated by a OHC code or Medicare coverage, and then shall bill the liable third parties for the cost of actual services rendered.

3. Contractor shall also bill the liable third parties for the cost of services provided to Members who are retroactively identified by Contractor or DHS as having OHC.

4. Contractor shall have written procedures implementing the above requirements. Contractor shall submit these procedures to DHS for review and comment.

F. Contractor shall initiate a Disenrollment for all Members whose eligibility record indicates OHC codes K, C, P, or F, within three (3) State working days after Contractor becomes aware of the OHC code. Until the Member is disenrolled, Contractor shall Cost Avoid or seek Post-Payment Recovery as specified in subsections D and E above.

G. Reporting Requirements

1. Contractor shall submit monthly reports to DHS, in a format prescribed by DHS, displaying claims counts and dollar amounts of costs avoided and the amount of Post-Payment Recoveries, by aid category, as well as the amount of outstanding recovery claims (accounts receivable) by age of account. The report shall display separate claim counts and dollar amounts for Medicare Part A and Part B. Reports shall be sent to the Department of Health Services, Third Party Liability Branch, Cost Avoidance Unit, P.O. Box 2471, Sacramento, CA 95812-2471.

2. When Contractor identifies OHC unknown to DHS, Contractor shall report this information to DHS within ten (10) days of discovery in automated format as prescribed by DHS. This information shall be sent to the Department of Health Services, Third Party Liability Branch, Health Identification Unit, P.O. Box 2471, Sacramento, CA 95812-2471.

3. Contractor shall demonstrate to DHS that where Contractor does not Cost Avoid or perform Post-Payment Recovery, that the aggregate cost of this activity exceeds the total revenues Contractor projects it would receive from such activity.

66. Article III, GENERAL TERMS AND CONDITIONS, renumbered Section 3.42, Third Party Tort Liability, is amended to read:

3.42 THIRD PARTY TORT LIABILITY/ESTATE RECOVERY

Contractor shall identify and notify DHS' Third Party Liability Branch of all instances or cases in which Contractor believes that an action by the Medi-Cal Member involving the tort or Workers' Compensation liability of a third party or estate recovery could result in recovery by the Member of funds to which DHS has lien rights under Article 3.5 (commencing with Section 14124.70), Part 3, Division 9, Welfare and Institutions Code. Contractor shall make no claim for recovery of the value of Covered Services rendered to a Member in such cases or instances and shall refer all such cases or instances to DHS' Third Party Liability Branch within ten (10) days of discovery. To assist DHS in exercising its responsibility for such recoveries, Contractor shall meet the following requirements:

A. If DHS requests service information and/or copies of paid invoices/claims for Covered Services to an individual Member, Contractor shall deliver the requested information within thirty (30) days of the request. Service information includes subcontractor and out-of-plan provider data. The value of the Covered Services shall be calculated as the usual, customary and reasonable charge made to the general public for similar services or the amount paid to subcontracted providers or out-of-plan providers for similar services.

B. Information to be delivered shall contain the following data items:

1. Member name.

2. Full 14-digit Medi-Cal number.

3. Social Security Number.

4. Date of birth.

5. Contractor name.

6. Provider name (if different from Contractor).

7. Dates of service.

8. Diagnosis code and description of illness/injury.

9. Procedure code and/or description of services rendered.

10. Amount billed by a subcontractor or out-of-plan provider to Contractor (if applicable).

11. Amount paid by other health insurance to Contractor or subcontractor (if applicable).

12. Amounts and dates of claims paid by Contractor to subcontractor or out-of-plan provider (if applicable).

13. Date of denial and reasons for denial of claims (if applicable).

14. Date of death (if applicable).

C. Contractor shall identify to DHS' Third Party Liability Branch the name, address and telephone number of the person responsible for receiving and complying with requests for mandatory and/or optional at-risk service information.

D. If Contractor receives any requests from attorneys, insurers, or beneficiaries for copies of bills, Contractor shall provide DHS' Third Party Liability Branch with a copy of any document released as a result of such request, and shall provide the name and address and telephone number of the requesting party.

E. Information submitted to DHS under this section shall be sent to Department of Health Services, Third Party Liability Branch, Recovery Section, P.O. Box 2471, Sacramento, CA 95812-2471.

67. Article III, GENERAL TERMS AND CONDITIONS, renumbered Section 3.43, Obtaining DHS Approval, is amended to read:

3.43 OBTAINING DHS APPROVAL

Contractor shall obtain written approval from DHS, as provided in Section 4.7, Approval Process, prior to implementing or using any of the following, including revisions to any of the items listed:

A. Providers of Covered Services, except for providers of seldom used or unusual services as determined by DHS.

B. Facilities.

C. Marketing activities.

D. Marketing materials, promotional materials, and public information releases relating to performance under this Contract, Member service guides; Member newsletters; and provider claim forms unique to the Contract.

E. Member Grievance procedure.

F. Member Disenrollment procedure.

G. Grievance forms.

H. Any other protocol, policy or procedure otherwise requiring approval under this Contract.

68. Article III, GENERAL TERMS AND CONDITIONS, renumbered Section 3.44, Pilot Projects, is amended to read:

3.44 PILOT PROJECTS

DHS, pursuant to W&I Code Section 14094.3(c)(2), may establish pilot projects to test alternative managed care models tailored to the special health care needs of children under the California Children Services (CCS) Program. These pilot projects may affect Contractor's obligations under the Contract in the areas of Covered Services, eligible enrollees, and administrative systems. These pilot projects shall be implemented through Contract amendment pursuant to Section 3.33, Amendment of Contract, and, if necessary, Change Order pursuant to Section 3.35, Change Requirements. DHS shall not require Contractor to cover CCS services under the capitation rate as part of a pilot project unless Contractor is a voluntary participant in the project.

69. Article III, GENERAL TERMS AND CONDITIONS, is amended by adding a new Section 3.45, to read:

3.45 RECORDS RELATED TO RECOVERY FOR TOBACCO RELATED ILLNESSES

3.45.1 RECORDS

DHS has filed a lawsuit for the recovery of medical expenses paid for the treatment of tobacco related illnesses, (People of the State of California ex rel. Daniel E. Lungren, Attorney General of the State of California; S. Kimberly Belshe, Director of Health Services of the State of California v. Philip Morris, Inc.; R.J. Reynolds Tobacco Company; Brown & Williamson Tobacco Corporation; B.A.T. Industries P.L.C.; Lorillard Tobacco Company, Inc.; American Tobacco Company, Inc.; United States Tobacco Company; Hill & Knowlton, Inc.; The Council for Tobacco Research-U.S.A., Inc.; Tobacco Institute, Inc.; Smokeless Tobacco Council, Inc. and Does 1 through 200, inclusive) (hereafter the "Tobacco Lawsuit"). Upon request by DHS, Contractor shall timely gather, preserve and provide to DHS, in the form and manner specified by DHS, any information specified by DHS, subject to any lawful privileges, in Contractor's or its subcontractors' possession, relating to the Tobacco Lawsuit. (If Contractor asserts that any requested documents are covered by a privilege, Contractor shall: 1) identify such privileged documents with sufficient particularity to reasonably identify the document

while retaining the privilege; and 2) state the privilege being claimed that supports withholding production of the document.) Such request shall include, but is not limited to, a response to a request for documents submitted by any defendant in the Tobacco Lawsuit. Contractor acknowledges that time may be of the essence in responding to some requests. Contractor shall use all reasonable efforts to immediately notify DHS of any subpoenas, document production requests, or requests for records, received by Contractor or its subcontractors related to tobacco related illnesses or the incidence of disease associated with the use of tobacco products.

3.45.2 PAYMENT FOR RECORDS

In addition to the payments provided for in Article V, DHS agrees to pay Contractor for complying with Section 3.45.1, Records, above, as follows:

A. DHS shall reimburse Contractor amounts paid by Contractor to third parties for services necessary to comply with Section 3.45.1. Any third party assisting Contractor with compliance with Section 3.45.1 shall comply with all applicable confidentiality requirements. Amounts paid by Contractor to any third party for assisting Contractor in complying with Section 3.45.1 shall not exceed normal and customary charges for similar services and such charges and supporting documentation shall be subject to review by DHS.

B. If Contractor uses existing personnel and resources to comply with Section 3.45.1, DHS shall reimburse Contractor as specified below. Contractor shall maintain and provide to DHS time reports supporting the time spent by each employee as a condition of reimbursement. Reimbursement claims and supporting documentation shall be subject to review by DHS.

    1. Compensation and payroll taxes and benefits, on a prorated basis, for the employees' time devoted directly to compiling information pursuant to Section 3.45.1.

    2. Costs for copies of all documentation submitted to DHS pursuant to Section 3.45.1, subject to a maximum reimbursement of ten (10) cents per copied page.

C. Contractor shall submit to DHS all information needed by DHS to determine reimbursement to Contractor under this section, including, but not limited to, copies of invoices from third parties and payroll records.

70. Article III, GENERAL TERMS AND CONDITIONS, is amended by adding a new Section 3.46 to read:

3.46 FRAUD AND ABUSE REPORTING

Contractor shall report to the Contracting Officer all cases of suspected fraud and/or abuse, as defined in 42 Code of Federal Regulations, Section 455.2, where there is reason to believe that an incident of fraud and/or abuse has occurred, by subcontractors, Members, providers, or employees within ten (10) State working days of the date when Contractor first becomes aware of or is on notice of such activity. Contractor shall establish policies and procedures for identifying, investigating and taking appropriate corrective action against fraud and/or abuse in the provision of health care services under the Medi-Cal program. Contractor shall notify DHS prior to conducting any investigations, based upon Contractor's finding that there is reason to believe that an incident of fraud and/or abuse has occurred, and, upon the request of DHS, consult with DHS prior to conducting such investigations. Without waiving any privileges of Contractor, Contractor shall report investigation results within ten (10) State working days of conclusion of any fraud and/or abuse investigation.

71. Article IV, DUTIES OF THE STATE, Section 4.3, Facility Inspections, is amended to read:

4.3 FACILITY INSPECTIONS

Conduct unannounced validation reviews on a number of Contractor's Primary Care sites, selected at DHS' discretion, to verify compliance of these sites with DHS requirements.

72. Article IV, DUTIES OF THE STATE, Section 4.4, Enrollment Processing, is amended to read:

4.4 ENROLLMENT PROCESSING

4.4.1 GENERAL

The parties to this Contract agree that the primary purpose of DHS' Medi-Cal managed care system is to improve quality and access to care for Medi-Cal beneficiaries. The parties acknowledge that the Medi-Cal eligibility process and the managed care enrollment system are dynamic and complex programs. The parties also acknowledge that it is impractical to ensure that every beneficiary eligible for enrollment in the Contractor's plan will be enrolled in a timely manner. Furthermore, the parties recognize

that for a variety of reasons some Eligible Beneficiaries will not be enrolled in Contractor's plan and will receive Covered Services in the Medi-Cal Fee-for-Service system. These reasons include, but are not limited to, the exclusion of some beneficiaries from participating in Medi-Cal managed care, the time it takes to enroll beneficiaries, changes in laws and policies, the loss and subsequent regaining of eligibility by beneficiaries, retroactive periods of eligibility for some beneficiaries, and the lack of a current valid address for some beneficiaries. The parties desire to work together in a cooperative manner so that Eligible Beneficiaries who choose to or should be assigned to Contractor's plan are enrolled in Contractor's plan pursuant to the requirements of Section 4.4. The parties agree that to accomplish this goal it is necessary to be reasonably flexible with regard to the enrollment process.

4.4.2 DEFINITIONS

For purposes of Section 4.4, Enrollment Processing, the following definitions shall apply:

A. Fully Converted County means a county in which the following circumstances - exist, except for those Medi-Cal beneficiaries covered by Title 22, CCR, Section 53887,:

1. Eligible Beneficiaries who meet the mandatory enrollment criteria contained in Tide 22, CCR, Section 53845(a) may no longer choose to receive Covered Services on a Fee-for-Service basis; and

2. All new Eligible Beneficiaries who meet the mandatory enrollment criteria contained in Title 22, CCR, Section 53845(a) must now choose a managed care plan or they will be assigned to a managed care plan; and

3. All Eligible Beneficiaries listed in MEDS as meeting the mandatory enrollment criteria contained in Title 22, CCR, Section 53845(a) on the last date that both 1. and 2. above occur:

(i) have been notified of the requirement to choose a managed care plan and informed that if they fail to choose a plan they will be assigned to a managed care plan; and

(ii) those beneficiaries still eligible for Medi-Cal and enrollment into a managed care plan at the time their plan enrollment is processed in MEDS have been enrolled into a managed care plan.

B. Mandatory Plan Beneficiary means:

1. A new Eligible Beneficiary who meets the mandatory enrollment criteria contained in Title 22, CCR, Section 53845(a) both at the time her/his plan enrollment is processed by the DHS Enrollment Contractor and by MEDS; or

2. An Eligible Beneficiary previously receiving Covered Services in a county without mandatory managed care enrollment who now resides in a county where mandatory enrollment is in effect and who meets the mandatory enrollment criteria contained in Title 22, CCR, Section 53845(a); or

3. An Eligible Beneficiary meeting the criteria of Title 22, CCR, Section 53845(b) prior to October 1, 1998, and who subsequently meets the criteria of Title 22, CCR, Section 53845(a).

C. Mandatory Plan Beneficiary shall not include any Eligible Beneficiary who:

(i) is eligible to receive Covered Services on a Fee-for-Service basis because her/his MEDS eligibility for managed care plan enrollment is interrupted due to aid code, ZIP code or county code changes; or

(ii) becomes eligible for enrollment in a managed care plan on a retroactive basis.

4.4.3 DHS ENROLLMENT OBLIGATIONS

A. DHS shall receive applications for enrollment from its enrollment contractor and shall verify the current eligibility of applicants for enrollment in Contractor's plan under this Contract. If the Contractor has the capacity to accept new enrollees, DHS or its enrollment contractor shall enroll or assign eligible applicants in Contractor's plan when selected by the applicant or when the applicant fails to timely select a plan. Of those to be enrolled or assigned in Contractor's plan, DHS will ensure that in a Fully Converted County a Mandatory Plan Beneficiary will receive an effective date of plan enrollment that is no later than 90 days from the date that MEDS lists such an individual as meeting the enrollment criteria contained in Title 22, CCR, Section 53845(a), if all changes to MEDS have been made to allow for the enrollment of the individual and all changes necessary to this Contract to accommodate such enrollment, including, but not limited to rate

changes and aid code changes, have been executed. DHS will use due diligence in making any changes to MEDS and to this Contract. DHS will provide Contractor a list of Members on a monthly basis.

B. DHS or its enrollment contractor shall assign Eligible Beneficiaries meeting the enrollment criteria contained in Title 22, CCR, Section 53845(a) to plans in accordance with Title 22, CCR, Section 53884.

C. Notwithstanding any other provision in this Contract, A. and B. above shall not apply to:

1. Eligible Beneficiaries previously eligible to receive Medi-Cal services from a Prepaid Health Plan or Primary Care Case Management plan and such plan's contract with DHS expires, terminates, or is assigned or transferred to Contractor;

2. Members who are enrolled into another managed care plan on account of assignment, assumption, termination, or expiration of this Contract;

3. Eligible Beneficiaries covered by a new mandatory aid code, added to this Contract after October 1, 1998;

4. Eligible Beneficiaries meeting the criteria of Title 22, CCR, Section 53845(b) prior to October 1, 1998, who subsequently meet the criteria of Title 22, CCR 53845(a) due solely to DHS designating a prior voluntary aid code as a new mandatory aid code;

5. Eligible Beneficiaries residing in a County that is not a Fully Converted County; or

6. Eligible Beneficiaries without a current valid deliverable address or with an address designated as a County post office box for homeless beneficiaries.

4.4.4 DISPUTES CONCERNING DHS ENROLLMENT OBLIGATIONS

A. Pursuant to the requirements and procedures contained in Section 3.20, Disputes and Appeals, Contractor shall notify DHS of DHS' noncompliance with Section 4.4, Enrollment Processing.

B. DHS shall have 120 days from the date of DHS' receipt of Contractor's notice (the "Cure Period") to cure any noncompliance with Section 4.4, Enrollment Processing, identified in Contractor's notice, without incurring any financial liability to Contractor. For purposes of this section, DHS shall be deemed to have cured any noncompliance with Section 4.4, Enrollment Processing, identified in Contractor's notice if within the Cure Period any of the following occurs:

1. Mandatory Plan Beneficiaries receive an effective date of plan enrollment that is within the Cure Period, or

2. DHS corrects enrollment that failed to comply with Section 4.4, Enrollment Processing, by redirecting enrollment from one Contractor to another within the Cure Period in order to comply with Section 4.4, Enrollment Processing, or

3. Within the Cure Period, DHS changes the distribution of beneficiary Assignment (subject to the requirements of Title 22, CCR, Section 53884(b)(l) through (b)(4)), to the maximum extent new beneficiaries are available to be assigned, to make up the number of incorrectly assigned beneficiaries as soon as possible.

C. If it is necessary to redirect enrollment or change the distribution of beneficiary Assignment due to noncompliance with Section 4.4, Enrollment Processing, and such change varies from the requirements of Title 22, CCR, Section 53884(b)(5) or (b)(6), Contractor agrees it will neither seek legal nor equitable relief for such variance or the results of such variance if DHS resumes assignment consistent with Sections 53884 (b)(5) or (b)(6) after correcting a noncompliance with Section 4.4, Enrollment Processing.

D. Notwithstanding Section 3.1 or any other provision of this Contract, if DHS fails to cure a noncompliance with Section 4.4, Enrollment Processing, within the Cure Period, DHS will be financially liable for such noncompliance as follows:

DHS will be financially liable for Contractor's demonstrated actual reasonable losses as a result of the noncompliance, beginning with DHS' first failure to comply with its enrollment obligation set forth herein. DHS' financial liability shall not exceed 15 percent of Contractor's monthly capitation payment calculated as if noncompliance with Section 4.4 did not occur, for each month in which DHS has not cured noncompliance pursuant to subparagraph 4.4.4.B, beginning with DHS' first failure to comply with its enrollment obligation set forth herein.

E. Notwithstanding Section 4.4.4.D above, DHS shall not be financially liable to Contractor for any noncompliance with Section 4.4, Enrollment Processing, in an affected county (on a county-by-county basis) if Contractor's loss of Mandatory Plan Beneficiaries, in a month in which any noncompliance occurs, is less than five percent of Contractor's total Members in that affected county in the month in which the noncompliance occurs. The parties acknowledge that the above-referenced five-percent threshold shall apply on a county-by-county basis, not in the aggregate.

73. Article IV, DUTIES OF THE STATE, Section 4.6, Testing and Certification of Marketing Representatives, is amended to read:

4.6 TESTING AND CERTIFICATION OF MARKETING REPRESENTATIVES

Test all Contractor Marketing Representatives for knowledge of the program prior to their engaging in Marketing or Medi-Cal Managed Care information activities on behalf of Contractor. Certify as qualified Marketing Representatives, those persons demonstrating adequate knowledge of the program, provided they are of good moral character. Contractor may be permitted, subject to approval and oversight by DHS, to perform such testing on behalf of DHS, provided that Contractor has never been sanctioned for Marketing violations or abuses. With respect to evidence of good moral character, Contractor shall be permitted to rely on the Marketing Representative's written statements. DHS reserves the right to rescind approval for Contractor testing at any time.

74. Article IV, DUTIES OF THE STATE, Section 4.7, Approval Process, is amended to read:

4.7 APPROVAL PROCESS

A. Within five (5) State working days of receipt, DHS shall acknowledge in writing the receipt of any material sent to DHS by Contractor pursuant to Article III, Section 3.3, Obtaining DHS Approval.

B. Within sixty (60) days of receipt, DHS shall make all reasonable efforts to approve in writing the use of such material provided to DHS pursuant to Article III, Section 3.43, Obtaining DHS Approval, provide Contractor with a written explanation why its use is not approved, or provide a written estimated date of completion of DHS' review process. If DHS does not complete its review of submitted material within sixty (60) days of receipt, or within the estimated date

of completion of DHS review, Contractor may elect to implement or use the material at Contractor's sole risk and subject to possible subsequent disapproval by DHS. This subsection shall not be construed to imply DHS approval of any material that has not received written DHS approval. This subsection shall not apply to Subcontracts or sub-subcontracts subject to DHS approval in accordance with Section 3.28.3, Departmental Approval - Non-Federally Qualified HMOs, or Section 3.28.4, Departmental Approval - Federally Qualified HMOs.

75. Article IV, DUTIES OF THE STATE, Section 4.8, Program Information, is amended to read:

4.8 PROGRAM INFORMATION

Provide Contractor with complete and current information with respect to pertinent policies, procedures, and guidelines affecting the operation of this Contract, within thirty (30) days of receipt of Contractor's written request for information, to the extent that the information is readily available. If the requested information is not available, DHS shall notify Contractor within thirty (30) days, in writing, of the reason for the delay and when Contractor may expect the information.

76. Article IV, DUTIES OF THE STATE, Section 4.9, Sanctions, is amended to read:

4.9 SANCTIONS

Apply sanctions, in accordance with Welfare and Institutions Code, Section 14304, and Title 22, CCR, Section 53872, to Contractor for violations of the terms of this Contract, applicable federal and State laws and regulations.

77. Article V, PAYMENT PROVISIONS, Section 5.2, Amounts Payable, is amended to read:

5.2 AMOUNTS PAYABLE

The maximum amount payable for the 1995-96 Fiscal Year ending June 30, 1996 will not exceed $32,080,630; the maximum amount payable for the 1996-97 Fiscal Year ending June 30, 1997 will not exceed $194,472,680; the maximum amount payable for the 1997-98 Fiscal Year ending June 30, 1998 will not exceed $6,500,000; the maximum amount payable for the 1998-99 Fiscal Year ending June 30, 1999 will not exceed $80,000,000. Any requirement for performance by DHS and the Contractor for the period of the Contract subsequent to June 30, 1999, will be dependent upon the

availability of future appropriations by the Legislature for the purpose of this Contract. If funds become available for purposes of this Contract from future appropriations by the Legislature, the maximum amount payable for the 1999-2000 Fiscal Year ending June 30, 2000 will not exceed $107,000,000; the maximum amount payable for the 2000-2001 Fiscal Year ending June 30, 2001 will not exceed $107,000,000; the maximum amount payable for the 2001-2002 Fiscal Year ending June 30, 2002 will not exceed $80,000,000. The maximum amount payable under this Contract will not exceed $607,053,310.

78. Article V, PAYMENT PROVISIONS, Section 5.3, Capitation Rates, is amended to read:

DHS shall remit to Contractor a capitation payment each month for each Medi-Cal Member that appears on the approved list of Members supplied to Contractor by DHS. The capitation rate shall be the amount specified in this Article. The payment period for health care services shall commence on the first day of operations, as determined by DHS. Capitation payments shall be made in accordance with the following schedule of capitation payment rates:

AID CODE CATEGORIES

Family: 01, 02, 08, 30, 32, 33, 34, 35, 38, 39, 3A, 3C, 3P, 3R, 40, 42, 4C, 4K, 54, 59, 5K; Aged: 10, 14, 16, 18; Disabled: 20, 24, 26, 28, 36, 60, 64, 66, 68, 6A, 6C; Child 03, 04, 45, 82; Adult 86

SAN BERNARDINO COUNTY 7/95 - 5/96		SAN BERNARDINO COUNTY 6/96 - 9/97	
Family	$ 70.01	Family	$ 71.59
Child	$ 67.91	Child	$ 67.17
Aged	$ 117.66	Aged	$ 121.76
Disabled	$ 177.15	Disabled	$ 174.45
Adult	$ 536.02	Adult	$ 554.73

RIVERSIDE COUNTY 7/95-5/96		RIVERSIDE COUNTY 6/96 - 9/97	
Family	$ 74.70	Family	$ 76.39
Child	$ 68.51	Child	$ 67.74
Aged	$ 110.37	Aged	$ 114.62
Disabled	$ 181.61	Disabled	$ 178.77

Adult	$ 492.78	Adult	$ 509.94

AID CODE CATAGORIES

Family: 01, OA, 02, 08, 30, 32, 3G, 33, 3H, 34, 35, 38, 39, 3A, 3C, 3N, 3U, 3P, 3R, 40, 42, 54, 59, 7X; CalWORKS: 3E, 3L, 3M; Aged: 10, 14, 16, 18; Disabled: 20, 24, 26, 28, 36, 60, 64, 66, 68, 6A, 6C, 6N, 6P, 6R; Child: 03, 04, 45, 4C, 4K, 5K, 82; Adult: 86

For the Period 10/97 - 09/30/98

RIVERSIDE COUNTY		SAN BERNARDINO	
Family	$ 75.91	Family	$ 74.04
Aged	$ 162.29	Aged	$ 167.25
Disabled	$ 204.96	Disabled	$ 217.87
Child	$ 79.33	Child	$ 79.42
Adult	$ 515.67	Adult	$ 531.42
AIDS Beneficiary Rate	$ 1021.49	Aids	$ 1072.78

In the future, DHS expects to activate aid codes 3N, 3U, 7X, 3E, 3L, 3M, 6N, 6P, and 6R, listed above by aid code rate category. If DHS activates these new aid codes, Contractor agrees to accept Eligible Beneficiaries with these aid codes as Members and to provide Covered Services to these Members at the monthly capitation rate specified for each rate category in this section.

79. Article V, PAYMENT PROVISIONS, Section 5.4, Capitation Rates Constitute Payment In Full, is amended to read:

5.4 CAPITATION RATES CONSTITUTE PAYMENT IN FULL

Capitation rates for each rate period, as calculated by DHS, are prospective rates and constitute payment in full, subject to any stop loss reinsurance provisions, on behalf of a Member for all Covered Services required by such Member and for all Administrative Costs incurred by Contractor in providing or arranging for such services, and subject to adjustments for federally qualified health centers in accordance with Section 5.13, but do not include payment for the recoupment of current or previous losses incurred by Contractor. DHS is not responsible for making payment for recoupment of losses. The actuarial basis for the determination of the capitation payment rates is outlined in Attachment 1 (consisting of twelve (12) pages).

80. Article V, PAYMENT PROVISIONS, Section 5.5, Determination of Rates, is amended to read:

5.5 DETERMINATION OF RATES

DHS shall determine the capitation rates for the initial period December 1, 1995, or the Contract effective date of operations if later, through September 30, 1997. Subsequent to September 30, 1997 and through the duration of the Contract, DHS shall make an annual redetermination of rates for each rate year defined as the 12-month period from October 1, through September 30. DHS reserves the right to redetermine rates on an actuarial basis or move to a negotiated rate for each rate year. All payments beyond June 1996 and rate adjustments beyond September 1997 are subject to future appropriations of funds by the Legislature and the Department of Finance approval. Further, all payments are subject to Title 42, CFR 447.361 and the availability of Federal congressional appropriation of funds.

If DHS redetermines rates on an actuarial basis, DHS shall determine whether the rates shall be increased, decreased, or remain the same. If it is determined by DHS that Contractor's capitation rates shall be increased or decreased, that increase or decrease shall be effectuated through a Change Order to this Contract in accordance with the provisions of Article III, Section 3.35, Change Requirements, subject to the following provisions:

A. The Change Order shall be effective as of October 1 of each year covered by this Contract.

B. In the event there is any delay in a determination to increase or decrease capitation rates, so that a Change Order may not be processed in time to permit payment of new rates commencing October 1, the payment to Contractor shall continue at the rates then in effect. Those continued payments shall constitute interim payment only. Upon final approval of the Change Order providing for the rate change, DHS shall make adjustments for those months for which interim payment was made.

C. Notwithstanding paragraph B, payment of the new annual rates shall commence no later than December 1, provided that a Change Order providing for the new annual rates has been issued by DHS. By accepting payment of new annual rates prior to full approval by all control agencies of the Change Order to this Contract implementing such new rates, Contractor stipulates to a confession of judgment for any amounts received in excess of the final approved rate. If the final approved rate differs from the rates agreed upon by Contractor and DHS:

1. Any underpayment by the State shall be paid to Contractor within 30 days after final approval of the new rates.

2. Any overpayment to Contractor shall be recaptured by the State's withholding the amount due from Contractor's next capitation check.

   If the amount to be withheld from that capitation check exceeds 25 percent of the capitation payment for that month, amounts up to 25 percent shall be withheld from successive capitation payments until the overpayment is fully recovered by the State.

D. If mutual agreement between DHS and Contractor cannot be attained on capitation rates for rate years subsequent to September 30, 1997 (resulting from a rate change pursuant to Section 5.5 or 5.6), Contractor shall retain the right to terminate the Contract, but no earlier than September 30, 1998. Notification of intent to terminate a Contract shall be in writing and provided to DHS at least nine (9) months prior to the effective date of termination, subject to any earlier termination date negotiated in accordance with Article III, Section 3.18.2, Termination - Contractor. DHS shall pay the capitation rates last offered for that rate period until the Contract is terminated.

E. DHS shall make every effort to notify and consult with Contractor regarding proposed redetermination of rates pursuant to this section or Section 5.6 at the earliest possible time prior to implementation of the new rate.

81. Article V, PAYMENT PROVISIONS, Section 5.6, Redetermination of Rates - Obligation Changes, is amended to read:

5.6 REDETERMINATION OF RATES - OBLIGATION CHANGES

The Capitation rates may be adjusted during the rate year to provide for a change in obligations which results in an increase or decrease of more than one percent of cost (as defined in Title 22, CCR, Section 53869) to Contractor. Any adjustments shall be effectuated through a Change Order to the Contract subject to the following provisions:

A. The Change Order shall be effective as of the first day of the month in which the change in obligations is effective, as determined by DHS.

B. In the event DHS is unable to process the Change Order in time to permit payment of the adjusted rates as of the month in which the change in obligations is effective, payment to Contractor shall continue at the rates then in effect. Continued payment shall constitute interim payment only. Upon final approval of the Change Order providing for the change in obligations, DHS shall make adjustments for those months for which interim payment was made.

C. DHS and Contractor may negotiate an earlier termination date, pursuant to Article III, Section 3.18.2, Termination - Contractor, if a change in contractual obligations is created by a State or federal change in the Medi-Cal program, or a lawsuit, that substantially alters the financial assumptions and conditions under which Contractor entered into this Contract, such that Contractor can demonstrate to the satisfaction of DHS that it cannot remain financially solvent until the termination date that would otherwise be established under this section.

82. Article V, PAYMENT PROVISIONS, Section 5.7, Reinsurance, subsection (A), sentence one, is amended to read:

Contractor may obtain reinsurance (stop loss coverage) through DHS or other insurers or may self-insure upon approval by DHS to ensure maintenance of adequate capital by Contractor, for the cost of providing Covered Services under this Contract.

83. Article V, PAYMENT PROVISIONS, Section 5.9, Financial Security, is amended to read:

5.9 FINANCIAL PERFORMANCE GUARANTEE

Contractor shall provide satisfactory evidence of and maintain Financial Performance Guarantee in an amount equal to at least one month's capitation payment, in a manner specified by DHS. At Contractor's request and with DHS approval, Contractor may establish a phase-in schedule to accumulate the required Financial Performance Guarantee. Contractor may elect to satisfy the Financial Performance Guarantee requirement by receiving payment on a post payment basis. The Financial Performance Guarantee shall remain in effect for a period not exceeding 90 days following termination or expiration of this Contract, unless DHS has a financial claim against Contractor.

84. Article V, PAYMENT PROVISIONS, Section 5.11, Recovery of Capitation Payments, is amended to read:

5.11 RECOVERY OF CAPITATION PAYMENTS

DHS shall have the right to recover amounts paid to Contractor in the following circumstances as specified:

A. DHS determines that a Member has either been improperly enrolled, due to ineligibility of the Member to enroll in Contractor's plan, residence outside of Contractor's Service Area, or pursuant to Title 22, Section 53891(a)(2), or should have been disenrolled with an effective date in a prior month. DHS may recover or, upon request by Contractor, DHS shall recover the capitation payments made to Contractor for the Member and absolve Contractor from all financial and other risk for the provision of services to the Member under the terms of the Contract for the month or months in question. In such event, Contractor shall have the authority to recover any payments made to providers for Covered Services rendered for the month or months in question. Contractor shall inform providers that claims for services provided to Members during the month or months in question shall be paid by DHS' fiscal intermediary, if the Member is determined eligible for the Medi-Cal program.

Upon request by Contractor, DHS may allow Contractor to retain the capitation payments made for Members that are eligible to enroll in Contractor's plan, but should have been retroactively disenrolled pursuant to Article VI, Section 6.7.2, Excluded Services: Circumstances Under Which Member Disenrolled, or under other circumstances as approved by DHS. If Contractor retains the capitation payments, Contractor shall provide or arrange and pay for all Medically Necessary Covered Services for the Member, until the Member is disenrolled on a nonretroactive basis pursuant to Article III, Section 3.23.5, Disenrollment.

B. As a result of Contractor's failure to perform contractual responsibilities to comply with federal Medicaid requirements, the Department of Health and Human Services (DHHS) disallows Federal Financial Participation (FFP) for payments made by DHS to Contractor. DHS may recover the amounts disallowed by DHHS by an offset to the capitation payments made to Contractor. If recovery of the full amount at one time imposes a financial hardship on Contractor, DHS at its discretion may grant a Contractor's request to repay the recoverable amounts in monthly installments over a period of consecutive months not to exceed six (6) months.

C. If DHS determines that any other erroneous or improper payment not mentioned above has been made to Contractor, DHS may recover the amounts determined by an offset to the capitation payments made to Contractor. If recovery of the full amount at one time imposes a financial hardship on Contractor, DHS, at its discretion, may grant a Contractor's request to repay the recoverable amounts in monthly installments over a period of consecutive months not to exceed six (6) months. At least thirty (30) days prior to seeking any such recovery, DHS shall notify Contractor to explain the improper or erroneous nature of the payment and to describe the recovery process.

85. Article V, PAYMENT PROVISIONS is amended by adding a new section 5.12 to read:

5.12 DATA REPORTING PERFORMANCE INCENTIVES

5.12.1 DEFINITIONS

For purposes of Section 5.12 Data Reporting Performance Incentives, the following definitions shall apply:

A. Financial Performance Incentive means the funds retained by DHS and paid to the Contractor upon Contractor's achieving the data reporting performance incentive standards contained in Section 5.12.3, Performance Incentive Standards.

B. Reporting Year means the twelve-month period beginning July 1, 1998 and ending June 30, 1999, and each subsequent twelve-month period beginning July 1 and ending June 30.

C. Services Reporting Period means the period during which Contractor provides the services counted to determine Contractor's compliance with the Children Served and Outpatient and Emergency Department Services standards, contained in Section 5.12.3, Performance Incentive Standards. The first Services Reporting Period shall consist of the first three months of the Reporting Year; the second Services Reporting Period shall consist of the first six months of the Reporting Year; the third Services Reporting Period shall consist of the first nine months of the Reporting Year, and the fourth Services Reporting Period shall consist of the entire 12 months of the Reporting Year.

D. Timeliness Reporting Period means the period during which Contractor reports data counted to determine Contractor's compliance with the Timeliness of Data Reporting Standards, contained in Section 5.12.3, Performance Incentive Standards. The first Timeliness Reporting Period shall consist of the first three months of the Reporting Year; the second timeliness Reporting Period shall consist of the first six months of the Reporting Years; the third Timeliness Reporting Period shall consist of the first nine months of the Reporting Year; and the fourth Timeliness Reporting Period shall consist of the entire 12 months of the Reporting Year.

E. Claim Run-Out Period means the period beginning on the first day of each Services Reporting Period of Timeliness Reporting Period and ending ninety (90) days after the last day of each Services Reporting Period or Timeliness Reporting Period.

F. Data Processing Period means the period beginning on the first day of each Services Reporting Period of Timeliness Reporting Period and ending ninety (90) days after the last day of each Claim Run-Out Period.

G. Evaluation Period means the ninety (90) day period beginning on the day after the last day of each Data Processing Period.

H. PM-160 Information Only Data means Child Health and Disability Prevention (CHDP) Encounter information contained on the Confidential Screening/Billing Report form used by the Contractor to report all CHDP Encounters to DHS and to the local CHDP program.

I. Encounter Record means an individual data entry, which follows the format code contained in the Managed Care Data Element Dictionary, reported to DHS for services provided to a Member during an Encounter.

5.12.2 PAYMENT PROVISIONS

For purposes of this Section 5.12, Data Reporting Performance Incentives, the following payment provisions shall apply:

A. Commencing with the monthly capitation payment for services provided by Contractor to Members during the month of April 1999, and for each subsequent monthly capitation payment, DHS shall retain and reserve one percent (1%) of each capitation payment for each county services by Contractor; however, in no event shall more than $100,000 per month be retained by DHS for a Contractor serving more than 150,000 Members. The retained funds reserved by DHS shall be allocated to each performance incentive standard as specified in Section 5.12.3, Performance Incentive Standards.

B. DHS shall pay Contractor the reserved Financial Performance Incentive funds allocated to each performance incentive standard, as provided in Section 5.12.3, Performance Incentive Standards, upon Contractor's achieving the standard, in a county serviced by Contractor under this Contract. If Contractor is providing services in multiple counties under this Contract, a Financial Performance Incentive payment shall only be paid for the county or counties in which Contractor achieves the specific performance incentive standard. If Contractor achieves a performance incentive standard in one county, this shall not affect the payment or nonpayment to Contractor for the same performance incentive standard in another county served under this Contract.

C. The funds available to each Financial Performance Incentive payment shall be the sum of all funds reserved by DHS for each performance incentive standard, as provided in Section 5.12.3, Performance Incentive Standards, for the Services Reporting Period or the Timeliness Reporting period under review, less any funds already paid to Contractor for achieving the standard in a previous Services Reporting Period or Timeliness Reporting Period in the same reporting year.

D. All Financial Performance incentive calculations for the percent of compliance with the standards described in Section 5.12.3, Financial Performance Standards, achieved by Contractor shall be rounded to the nearest whole number according to the following: all percentages shall be carried out to two (2) decimal places and those ending with 0.49 or less shall be rounded down to the next lower whole number, and all percentages ending with 0.50 or more shall be rounded up to the next higher whole number.

E. DHS shall notify Contractor of the results of its determination of Contractor's compliance with each performance incentive standard not later than ten (10) working days after the end of the Evaluation Period for the Services Reporting Period or Timeliness Reporting Period under review. The Financial Performance Incentive payment shall be included in Contractor's monthly capitation payment, no later than the second month after the last day of the Evaluation Period.

F. Payments to Contractor for achieving a performance incentive standard shall be subject to verification reviews, including but not limited to review of Member medical records, by DHS. If, based upon such review, Contractor did not achieve compliance with a performance incentive standard, DHS shall recover any Financial Performance Incentive payments made to Contractor for achieving the standard. Contract shall timely and fully cooperate with DHS, and required timely and full cooperation of all entities subcontracting with Contractor, in the conduct of verification reviews and the furnishing of all records and information requested by DHS to complete the reviews. Contractor shall not be compensated, including but not limited to compensation for copies of information, for cooperating in such reviews. Contractor's failure to cooperate in verification reviews, as determined by DHS in its sole discretion, shall be grounds for DHS' recovery of any payments made for achieving a performance incentive standard.

G. If DHS fails to determine Contractor's compliance with a performance incentive standard and mail notification to Contractor of the results of such determination within ten (10) working days after the end of the Evaluation Period for the Services Reporting Period or Timeliness reporting Period under review, DHS shall pay Contractor the Financial Performance Incentive allocated to the standard for which DHS failed to timely determine compliance. Such payment shall be included in Contractor's monthly capitation payment, no later than the second month after the last day of the Evaluation Period.

H. Contractor may dispute any determination of compliance with performance incentive standards made by DHS under Section 5.12, Data Reporting Performance Incentives, by filing a notice of dispute pursuant to Section 3.xx, Disputes and Appeals. Contractor shall comply with all provisions of Section 3.xx, Dispute and Appeals, in disputing any determination of compliance with performance incentive standards made by DHS pursuant to Section 5.12, Data Reporting Performance Incentives. Contract shall exhaust all procedures provided for in Section 3.xx, Dispute and Appeals, prior to initiating any other action to enforce Section 5.12 Data Reporting Performance Incentives.

I. DHS shall pay interest to Contractor for funds reserved from or subsequently paid to Contractor, under Section 5.12, Data Reporting Performance Incentives.

5.12.3 PERFORMANCE INCENTIVE STANDARDS

Contractor shall be eligible for payment of Financial Performance Incentive payments as set forth in Section 5.12, Data Reporting Performance Incentives, upon compliance with the following standards:

A. Children Served

1. PM-160 Information Only Data submitted by Contractor, that meets the requirements in paragraph 3 below, shall demonstrate compliance with the applicable county rte specified in Table 1 below, for the applicable Services Reporting Period. Contractor's failure to achieve the required standard for any Services Reporting Period, shall not prevent Contractor from receiving payment of the Financial Performance Incentive payment for such Services Reporting Period, if in a subsequent Services Reporting Period, within the same Reporting

Year, Contractor achieves the standard required for the subsequent Services Reporting Period.

Table 1: Required % of Member Children Served to Qualify for Incentive Payments

County	By End of Reporting Period 1	By End of Reporting Period 2	By End of Reporting Period 3
Alameda	****8%	****16%	****24%
Contra Costa	****7	****14	****21
Fresno	****8	****16	****24
Kern	****8	****16	****24
Los Angeles	****8	****16	****24
Riverside	****6	****12	****18
San Bernardino	****7	****14	****21
San Francisco	****7	****14	****21
San Joaquin	****8	****16	****24
Santa Clara	****7	****14	****21
Stanislaus	****6	****12	****18
Tulare	****6	****12	****18

County	By End of Reporting Period 4
Alameda	****32%
Contra Costa	****28
Fresno	****31
Kern	****30
Los Angeles	****30
Riverside	****24
San Bernardino	****27
San Francisco	****26
San Joaquin	****30
Santa Clara	****29
Stanislaus	****25
Tulare	****23

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**** - Greater than or Equal to

2. Compliance with the Children Services standard shall be based on the unduplicated count of Member children, who were enrolled in Contractor's plan for at least one month during the Services Reporting Period and who were at least four (4) months of age, but less than six (6) years of age during the month in which a reported pediatric preventive service encounter occurred. Information may be reported in hard copy or via computer media claiming, to the extent such arrangements are available to Contractor. This shall not be construed as creating any obligation on DHS to make available to Contractor or condition Contractor performance under this section on the availability of computer medial claiming submission.

3. DHS' determination as to whether Contractor has achieved the performance incentive standard for Children Served shall be based solely on evaluation of PM-160 Information Only Data:

   a. Documenting CHDP services rendered to Members with a date of service during the Services Reporting Period;

   b. Submitted to DHS by Contractor no later than the last day of the Claims Run-Out Period for the Services Reporting Period under review; and

   c. Accepted by DHS' fiscal intermediary for processing.

4. PM-160 Information Only Data submitted by Contractor during a Claim Run-Out Period that is rejected by DHS' fiscal intermediary shall not be included in DHS' evaluation for the purposes of this section unless it is resubmitted by Contractor and meets the requirements in paragraph 3 above. However, solely for purposes of evaluation contractor's eligibility to receive Financial Performance Incentive payments, PM-160 Information Only Data resubmitted after the end of the Claims Run-Out Period and accepted for processing by DHS' fiscal intermediary shall be included in DHS' evaluation for subsequent Services Reporting Periods within the same Reporting Year if such data is received by DHS no later than the last day of the Claims Run-Out Period for the last Services Reporting Period of the Reporting Year. The provisions of subsection 5.12.3.A.4 apply only to evaluating Contractor's compliance with the performance incentive standards and do not relieve Contractor of the obligation to report CHDP Encounters in compliance with Article VI, Section 6.7.6.2, Children, nor shall this section be construed to limit DHS' right to imposed all appropriate sanctions for Contractor's failure to comply with Article VI, Section 6.7.6.2, Children.

5. Thirty-five percent (35%) of the funds reserved by DHS each month, for each county in which contractor provides services under this Contract, shall be allocated to the Children Served performance incentive standard.

6. DHS shall pay Contractor for achieving the performance incentive standard for Children Serviced based upon the graduated payment schedule shown in Table 2 below. Each Financial Performance Incentive payment shall be the sum of all funds reserved by DHS for the Children Serviced standard for the Services Reporting Period under review, minus any funds already paid to Contractor for compliance with the Children Served standard in a previous Services Reporting Period in the same Reporting Year, multiplied by the amount of Financial Incentive Payment shown in Table 2 that was achieved by Contractor for the Children Served performance incentive standard.

Table 2: PM-160 Payment Criteria for Children Served and Outpatient and Emergency Department Services Performance Incentive Standards

% of Compliance Standard Achieved	Amount of Financial Incentive Payment
100%	100% of funds reserved for the relevant standard
76-99%	75% of funds reserved for the relevant standard
51-75%	50% of funds reserved for the relevant standard
26-50%	25% of funds reserved for the relevant standard
0-25%	0% of funds reserved for the relevant standard

B. Outpatient and Emergency Department Service Encounters

1. For each county in which Contractor operates under this Contract, Contractor shall demonstrate compliance with the applicable utilization rate per 1,000 Members specified in Table 3 below, for each Services Reporting Period, and based upon Contractor's length of operations. Contractor's failure to achieve the required standard for any Services Reporting Period, shall not prevent Contractor from receiving payment of the Financial Performance Incentive for such Services Reporting Period, if in a subsequent Services Reporting Period, within the same Reporting Year, Contractor achieves the standard required for the subsequent Services Reporting Period.

Table 3: Utilization Rate Per 1,000 Members

Length of Operations Under Two-Plan Model Contract	Outpatient and Emergency Department Utilization Rate Per 1,000 Members Required to Qualify for Financial Incentive Payment (based on an annualized rate of 2,760 encounters per 1,000 members)			
	Services Reporting Period			
	1	2	3	4
Less than 12 months	****207/1,000	****414/1,000	****621/1,000	****828/1,000
More than 12 months, but less than 24 months	****345/1,000	****690/1,000	****1,035/1,000	****1,380/1,000
More than 24 months	****455/1,000	****910/1,000	****1,365/1,000	****1,822/1,000

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**** - Greater than or equal to

2. Contractor's length of operations under this Section 5.12, Data Reporting Performance Incentives, shall be determined based upon the amount of time Contractor has been providing Covered Services under this Contract as of the last day of each Services Reporting Period. However, if Contractor's length of operations category changes after the last day of the ninth month of the Reporting Year, DHS shall use the Contractor's previous length of operations category to evaluate Contractor's compliance with the Outpatient and Emergency Department Services standard for the entire Reporting Year.

3. Compliance with the Outpatient and Emergency Department Service Encounters standard shall be based on the outpatient and emergency department services Encounters, exclusive of PM-160 Information Only Data, reported by Contractor to DHS as provided to Members in each county in which the Contractor operations with a data of service during the Services Reporting Period. Contractor performance shall be determined using an unduplicated count of Members, who were enrolled in Contractor's plan in each county for at least one month during the Services Reporting Period under review.

4. DHS' determination as to whether Contractor has met the standard for Outpatient and Emergency Department Service Encounters shall be based solely on evaluation of the Encounter data, exclusive of PM-160 Information Only Data, for outpatient and emergency department services, as described in HEDIS 3.0, Ambulatory Care, rendered to Members with a data of service during the Services Reporting Period under review, and that Contractor has submitted to DHS no later than the last day of the Claim Run-Out Period for the Services Reporting Period under review and has been accepted for processing by DHS' fiscal intermediary. Encounter data submitted by Contractor during a Claim Run-Out Period that is rejected by DHS' fiscal intermediary shall not be included in DHS' evaluation for the purposes of this section unless it is resubmitted no later than the last day of the Claim Run-Out Period and accepted for processing by DHS' fiscal intermediary. However, solely for the purposes of evaluating Contractor's eligibility to receive financial Performance Incentive payments, non-PM 160 Encounter data submitted or resubmitted after the end of the claims Run-Out Period and accepted for processing DHS' fiscal intermediary shall be included in DHS' evaluation for subsequent Services Reporting Periods within the same Reporting Year if such data is received by DHS no later than the last day of the claim Run-Out Period for the last Services Reporting Period of the reporting Year. The provisions of this subsection 5.12.3.B.4 apply only to evaluating Contractor's compliance with the Outpatient and Emergency Department Services Encounters performance incentive standard and do not relieve Contractor of the obligation to report Encounter data in compliance with Article VI, Section 6.4, Management Information System.

5. Thirty-five percent (35%) of the total funds reserved by DHS for each month shall be allocated to the Outpatient and Emergency Department Service Encounters performance incentive standard.

6. DHS shall pay Contractor for achieving the performance incentive standard for Outpatient and Emergency Department Service Encounters according to the graduated payment schedule provided in Table 2 of Section 5.12.3, Performance Incentive Standards, paragraph A.5. Each Financial Performance Incentive payment shall be the sum of all funds reserved by DHS for the Outpatient and Emergency Department Encounter standard for the Services Reporting Period under review, less any funds already paid to Contractor for compliance with the Outpatient and Emergency Department Service Encounter standard in a previous Services Reporting Period in the same Reporting Year, multiplied by the amount of Financial Incentive Payment shown in able 3 that was achieved by Contractor for the Outpatient and Emergency Department Service Encounter performance incentive standard.

C. Timeliness of Data Reporting

1. Timeliness of PM-160 Information Only Data Reporting: To receive a Financial Performance Incentive payment for Timeliness of PM-160 Information Only Data reporting, for any Timeliness Reporting Period, Contractor shall meet or exceed:

   a. Seventy-five period (75%) of the applicable standard for Children Served for the Timeliness Reporting Period under review, and

   b. Seventy-five percent (75%) of all PM-160 Information Only Data submitted by Contractor during the Timeliness Reporting Period under review, shall be submitted within thirty (30) days of the end of the month in which the PM-160 Encounter occurred, in accordance with Article VI, Section 6.7.6.2, Children, subsection H, and accepted for processing by DHS' fiscal intermediary no later than the last day of the Timeliness Reporting Period. PM-160 Information Only Data originally submitted during the Timeliness Reporting Period under review, but rejected for processing by DHS' fiscal intermediary, resubmitted after the Timeliness Reporting Period under review and accepted by DHS' fiscal intermediary no later than the last day of the subsequent Timeliness Reporting Period shall be included in DHS' evaluation for the subsequent Timeliness Reporting Period. Notwithstanding the above, only PM-160 Information Only Data received by DHS and accepted for processing by DHS' fiscal intermediary no later than June 30 of the Reporting Year under review shall be considered for Contractor's compliance with the Timeliness of PM-160 Information Only Data Reporting standard for that Reporting Year.

2. Timeliness of Encounter Data Reporting: To receive a Financial Performance Incentive payment for timeliness of Encounter data reporting, for any Timeliness Reporting Period, Contractor shall meet or exceed:

   a. Seventy-five percent (75%) of the applicable standard for Outpatient and Emergency Department Service Encounters for the Timeliness Reporting Period under review; and

b. Seventy percent (70%) of all Encounter Records submitted by Contractor during the Timeliness Reporting Period under review, shall be submitted within ninety (90) days of the end of the month in which the Encounter occurred, and accepted for processing by DHS' fiscal intermediary and DHS no later than the last day of the Timeliness Reporting Period. Encounter Records originally submitted to DHS during the Timeliness Reporting Period under review, but rejected for processing by DHS' fiscal intermediary or DHS, resubmitted after the Timeliness Reporting Period under review and accepted for processing by DHS' fiscal intermediary and DHS no later than the last day of the subsequent Timeliness Reporting Period shall be included in DHS' evaluation for the subsequent Timeliness Reporting Period. Notwithstanding the above, only Encounter Records received by DHS and accepted for processing by DHS' fiscal intermediary and DHS no later than June 30 of the Reporting Year under review shall be considered for Contractor's compliance with the Timeliness of Encounter Data Reporting standard for that Reporting Year.

3. Fifteen percent (15%) of the total funds reserved by DHS for each month shall be allocated to the Timeliness of PM-160 Information Only Data Reporting standard, and fifteen percent (15%) of the total funds reserved by DHS for each month shall be allocated to the Timeliness of Encounter Data reporting standard.

4. Each Financial Performance Incentive payment shall be the sum of all funds reserved by DHS for the Timeliness of PM-160 Information Only Data Reporting standard for the Timeliness Reporting Period under review, less any funds already paid to Contractor for compliance with such Timeliness standard in a previous Timeliness Reporting Period in the same Reporting Year.

5. Each Financial Performance Incentive payment shall be the sum of all funds reserved by DHS for the Timeliness of Encounter Data Reporting standard for the Timeliness Reporting Period under review, less any funds already paid to Contractor for compliance with such Timeliness standard in a previous Timeliness Reporting Period in the same Reporting Year.

86. Article V, PAYMENT PROVISIONS is amended by adding a new Section 5.13, FQHC/RHC Risk Corridor Payments, to read:

5.13 FQHC/RHC RISK CORRIDOR PAYMENTS

Beginning October 1, 1997 and through September 30, 2000, provided that Contractor annually submits, within four months after the last day of each fiscal year, required expenditure data to DHS in the form and manner specified by DHS, DHS shall perform reconciliations to determine the variance between the funds that have been paid to Contractor in its capitation rates to reflect the dollar value of FQHC and RHC interim rate payments made to these entities in the Medi-Cal FFS program and the amount that Contractor has paid to subcontracting FQHCs and RHCs.

For each annual reconciliation, if, pursuant to subcontracts with FQHCs and RHCs that have been reviewed and approved in writing by DHS, Contractor has paid subcontracting FQHCs and RHCs in the aggregate an amount greater than 110 percent of the dollar value of FQHC and RHC interim rate payments included in Contractor's capitation rates, DHS shall pay Contractor the amount in excess of 110 percent.

For each annual reconciliation, if, pursuant to subcontracts with FQHCs and RHCs that have been reviewed and approved in writing by DHS, Contractor has paid subcontracting FQHCs and RHCs in the aggregate an amount less than 90 percent of the dollar value of FQHC and RHC interim rate payments included in Contractor's capitation rates, Contractor shall refund the amount below 90 percent to DHS. DHS may recover amounts owed by Contractor pursuant to this section through an offset to the capitation payments made to Contractor, pursuant to Section 5.11(C), Recovery of Capitation Payments.

All reconciliations shall be subject to an annual reconciliation audit at which time payments to or recoupments from Contractor shall be finalized.

87. Article V, PAYMENT PROVISIONS, is amended by adding a new Section 5.14, Payment of AIDS Beneficiary Rates, to read:

5.14 PAYMENT OF AIDS BENEFICIARY RATES

Subject to Contractor's compliance with the requirements contained in subsection A below, Contractor shall be eligible to receive compensation at the AIDS Beneficiary Rate (ABR) for AIDS Beneficiaries. Compensation to Contractor at the ABR for each AIDS Beneficiary shall consist of payment at the ABR less the capitation rate initially paid for the AIDS beneficiary.

A. Compensation at the ABR shall be subject to the conditions listed below. Contractor's failure to comply with any of the conditions listed below for any request for compensation at the ABR on behalf of an individual AIDS Beneficiary for a specific month of Enrollment shall result in DHS' denial of Contractor's claim for compensation at the ABR for that individual AIDS Beneficiary for that specific month of Enrollment. Contractor may submit a corrected claim, within the timeframes specified in paragraph 4 below, that complies with all the conditions listed below and DHS shall reimburse Contractor at the ABR.

1. The ABR shall be in lieu of any other compensation for an AIDS Beneficiary in any month.

2. For AIDS Beneficiaries, Contractor shall be eligible to receive compensation at the ABR commencing in the month in which a Diagnosis of AIDS is made and recorded, dated and signed by the treating physician in the AIDS Beneficiary's Medical Record.

3. Contractor shall submit an invoice to DHS by the 25th day of each month for claims for compensation at the ABR for AIDS Beneficiaries. The invoice shall include the following:

   a. A list of all AIDS Beneficiaries identified by Medi-Cal numbers only for whom Contractor is claiming compensation at the ABR Member names shall not be used.

   b. The month(s) and year(s) for which compensation at the ABR is being claimed for each AIDS Beneficiary listed, sorted by month and year of service.

   c. The capitation rate initially paid for the AIDS Beneficiary for each month being claimed by Contractor, the ABR being claimed, and the difference between the ABR and the capitation rate initially paid for the AIDS Beneficiary.

   d. The total amount being claimed on the invoice.

4. Invoices, containing originally submitted claims or corrected claims, for compensation at the ABR for any month of eligibility during the rate year beginning October 1, 1997 and ending September 30, 1998, or any rate year thereafter beginning October 1 and ending September 30, must be submitted by Contractor to DHS no later than six (6) months following the end of the subject rate year.

B. Contractor shall confirm Medi-Cal eligibility of AIDS Beneficiaries prior to submission of the monthly invoice to DHS. DHS may verify the Medi-Cal eligibility of each Member for whom the ABR is claimed and adjust the invoiced amounts to reflect any capitation payments which have been previously made to Contractor for each Member prior to submission of the invoice required under subsection A(3).

C. If DHS determines that a Member for whom compensation has been paid at the ABR did not meet the definition of an AIDS Beneficiary, in a month for which the ABR was paid, DHS shall recover any amount improperly paid, by an offset to Contractor's capitation payment, in accordance with Section 5.11(C), Recovery of Capitation Payments. DHS shall give Contractor thirty (30) days prior written notice of any such offset.

88. Article VI, SCOPE OF WORK, Section 6.2.5, Administrative Duties/Responsibilities, subsection (B), is amended to read:

B. Member and Enrollment reporting systems as specified in Section 6.4, Management Information Systems (MIS), and Section 6.9, Member Services/Grievance Systems.

89. Article VI, SCOPE OF WORK, Section 6.3.1, Financial Viability/Standards Compliance, is amended to read:

6.3.1 FINANCIAL VIABILITY/STANDARDS COMPLIANCE

Contractor shall demonstrate financial viability/standards compliance to DHS' satisfaction for each of the following elements:

A. Tangible Net Equity (TNE).

Contractor at all times shall be in compliance with the TNE requirements in accordance with Title 10, CCR, Section 1300.76.

B. Administrative Costs.

Contractor's Administrative Costs shall not exceed the guidelines as established under Title 10, CCR, Section 1300.78.

C. Standards of Organization and Financial Soundness.

Contractor shall maintain an organizational structure sufficient to conduct the proposed operations and ensure that its financial resources are sufficient for sound business operations in accordance with Title 10, CCR, Sections 1300.67.3, 1300.75.1, 1300.76, 1300.76.3, 1300.77.1, 1300.77.2, 1300.77.3, 1300.77.4, 1300.78, and Title 22, CCR, Sections 53851, 53863, and 53864.

D. Working capital and current ratio of one of the following:

1. Contractor shall maintain a working capital ratio of at least 1:1; or

2. Contractor shall demonstrate to DHS that Contractor is now meeting financial obligations on a timely basis and has been doing so for at least the preceding two years; or

3. Contractor shall provide evidence that sufficient noncurrent assets, which are readily convertible to cash, are available to achieve an equivalent working capital ratio of 1:1, if the noncurrent assets are considered current.

90. Article VI, SCOPE OF WORK, Section 6.3.2, Financial Audit/Reports, is amended to read:

6.3.2 FINANCIAL AUDIT/REPORTS

Contractor shall ensure that an annual audit is performed according to Section 14459, W&I Code. Combined Financial Statements shall be prepared to show the financial position of the overall related health care delivery system when delivery of care or other services is dependent upon Affiliates. Financial Statements shall be presented in a form that clearly shows the financial position of Contractor separately from the combined totals. Inter-entity transactions and profits shall be eliminated if combined statements are prepared. Contractor shall have separate certified Financial Statements prepared if an independent accountant decides that preparation of combined statements is inappropriate.

A. The independent accountant shall state in writing reasons for not preparing combined Financial Statements.

B. Contractor shall provide supplemental schedules that clearly reflect all inter-entity transactions and eliminations necessary to enable DHS to analyze the overall financial status of the entire health care delivery system.

1. In addition to annual certified Financial Statements Contractor shall complete the entire 1989 HMO Financial Report of Affairs and Conditions Format, commonly known as the "Orange Blank". The Certified Public Accountant's (CPA) audited Financial Statements and the "Orange Blank" report shall be submitted to DHS no later than 120 calendar days after the close of Contractor's Fiscal Year.

2. Contractor shall submit to DHS within forty-five (45) calendar days after the close of Contractor's fiscal quarter financial reports required by Title 22, CCR, Section 53862(b)(l). The required quarterly financial reports shall be prepared on the "Orange Blank" format and shall include, at a minimum, the following reports/schedules:

a. Jurat.

b. Report 1A and 1B: Balance Sheet.

c. Report 2: Statement of Revenue, Expenses, and Net Worth.

d. Statement of Cash Flow, prepared in accordance with Financial Accounting Standards Board Statement Number 95 (This statement is prepared in lieu of Report #3: Statement of Changes in Financial Position for Generally Accepted Accounting Principles (GAAP) compliance.)

e. Report 4: Enrollment and Utilization Table.

f. Schedule F: Unpaid Claims Analysis.

g. Appropriate footnote disclosures in accordance with GAAP.

C. Contractor shall authorize the independent accountant to allow representatives of DHS, upon written request, to inspect any and all working papers related to the preparation of the audit report.

D. Contractor shall submit to DHS all financial reports relevant to Affiliates as specified in Title 22, CCR, Section 53862(c)(4).

E. Contractor shall submit to DHS copies of any financial reports submitted to other public or private organizations as specified in Title 22, CCR, Section 53862(c)(5).

91. Article VI, SCOPE OF WORK, is amended by adding a new Section 6.3.6, Submittal of FQHC and RHC Payment Information, to read:

6.3.6 SUBMITTAL OF FQHC AND RHC PAYMENT INFORMATION

Effective with the October 1997 month of service, Contractor shall keep a record of the number of visits by plan Members to each FQHC and RHC contracting with Contractor and related payment information, and shall submit this information to DHS in the frequency, format, and manner specified by DHS. This requirement shall remain in effect through the September 1999 month of service.

92. Article VI, SCOPE OF WORK, is amended by adding a new Section 6.3.7, Submittal of Inpatient Days Information, to read:

6.3.7 SUBMITTAL OF INPATIENT DAYS INFORMATION

Upon DHS' written request, Contractor shall report inpatient days to DHS as required by W&I Code, Section 14105.985(b)(2) for the time period and in the form and manner specified in DHS' request, within thirty (30) days of receipt of the request. Contractor shall submit additional reports to DHS, as requested, for the administration of the Disproportionate Share Hospital program.

93. Article VI, SCOPE OF WORK, Section 6.4, Management Information System, is amended to read:

6.4.1 MANAGEMENT INFORMATION SYSTEM (MIS) CAPABILITY

Contractor shall have and maintain an MIS that provides, at a minimum:

A. All Medi-Cal eligibility data,

B. Members enrolled in Contractor's plan,

C. Provider claims status and payment data,

D. Encounter-level health care services delivery data,

E. Provider network information, and

F. Financial information as specified in Section 6.2.5(E), Administrative Duties/Responsibilities.

6.4.2 ENCOUNTER DATA SUBMITTAL

Contractor shall implement policies and procedures for ensuring the complete, accurate, and timely submission of Encounter-level data for all services for which Contractor has incurred any financial liability, whether directly or through Subcontracts or other arrangements. As a condition of payment, Contractor may require subcontractors and out-of-plan providers to provide Encounter-level data to Contractor that meets the same standards required for Contractor to comply with this section. Contractor shall submit

Encounter-level data to DHS on a monthly basis, no later than ninety (90) days following the end of the reporting month in which the Encounter occurred, in the form and manner specified in DHS' most recent Managed Care Data Element Dictionary. Encounter-level data received and processed by Contractor too late to be submitted timely, shall be submitted to DHS with the next monthly submission. Encounter-level data shall include data elements specified in DHS' most recent Managed Care Data Element Dictionary.

6.4.3 MIS/DATA CORRESPONDENCE

Contractor shall ensure, that upon written notice by DHS of any problems related to the submittal of data or any changes or clarifications related to Contractor's MIS system, that Contractor shall submit to DHS a Corrective Action Plan with measurable benchmarks within thirty (30) calendar days from the date of the postmark of DHS' written notice to Contractor. Within thirty (30) days of DHS' receipt of Contractor's Corrective Action Plan, DHS shall approve the Corrective Action Plan or request revisions. Within fifteen (15) days after receipt of a request for revisions to the Corrective Action Plan, Contractor shall submit a revised Corrective Action Plan for DHS approval.

6.4.4 TIMELY, COMPLETE AND ACCURATE DATA SUBMISSION

Contractor shall ensure that the Encounter-level data submitted to DHS are complete, accurate, and timely and in compliance with the requirements of DHS' most recent Managed Care Data Element Dictionary.

Upon written notice by DHS that Encounter-level data is insufficient or inaccurate, Contractor shall ensure that corrected data is resubmitted within fifteen (15) days of receipt of DHS' notice. Upon Contractor's written request, DHS may provide a written extension of the time to resubmit corrected Encounter-level data.

94. Article VI, SCOPE OF WORK, Section 6.5.3.3, Standards and Guidelines, subsection A, is amended to read:

A. Pediatric:

Periodic health screen schedule based on the most recent recommendations of the American Academy of Pediatrics (AAP). Immunization schedule based on recommendations of either the Advisory Committee on Immunization Practices or the AAP shall be acceptable.

95. Article VI, SCOPE OF WORK, Section 6.5.3.4, Quality Indicators, is amended to read:

6.5.3.4 QUALITY INDICATORS

To the extent feasible and appropriate, Contractor shall use the most recent HEDIS indicators for the required Quality of Care studies indicated in Section 6.5.3.2, Quality of Care Studies. The HEDIS indicators selected for use by Contractor shall be approved by DHS.

96. Article VI, SCOPE OF WORK, Section 6.5.5.2, Facility Review Procedures, subsection O, is amended to read:

6.5.5.2 REVIEW PROCEDURES

O. Informed consent procedures.

97. Article VI, SCOPE OF WORK, Section 6.5.5.3, Number of Sites to be Reviewed Prior to Operations, is amended to read:

6.5.5.3 NUMBER OF SITES TO BE REVIEWED PRIOR TO OPERATIONS

Contractor shall ensure that Facility reviews are completed on thirty (30) sites or a five (5) percent sample of the total number of Primary Care sites, whichever is less, prior to initiating plan operation or new site expansion. Contractors with 30 sites or less, or who are expanding by 30 sites or less, shall complete Facility reviews on all sites prior to initiating operation. A Contractor with NCQA accreditation is exempted from this requirement.

Contractor shall submit the results of pre-operational and expansion site reviews to DHS at least six (6) weeks prior to plan or site operation. For pre-operational site reviews, Contractor shall submit the Primary Care Facility Identification form, the facility checklist, and any corrective actions and follow-up. For expansion site reviews, Contractor shall submit an aggregate report of the review results without the Primary Care Facility Identification form or facility checklist.

98. Article VI, SCOPE OF WORK, Section 6.5.5.5, DHS Facility Inspections, is amended to read:

6.5.5.5 FACILITY INSPECTIONS

Contractor shall provide any necessary assistance to DHS in its conduct of Facility inspections and medical reviews of the Quality of Care being provided to Members. Contractor shall ensure correction of deficiencies as identified by those inspections and reviews according to the timeframes delineated by DHS in the resulting reports.

99. Article VI, SCOPE OF WORK, Section 6.5.5.6, Corrective Actions, is amended to read:

6.5.5.6 CORRECTIVE ACTIONS

Contractor shall ensure that Primary Care sites with major, uncorrected deficiencies are not allowed to begin operation. In the event a Primary Care site develops such deficiencies subsequent to the commencement of operations, Contractor shall require such site to cease providing services to Members; provided that such site may not be required to cease providing services in the event DHS and Contractor agree to a plan of corrective action to be implemented by the site, and such plan is being implemented to the satisfaction of DHS.

100. Article VI, SCOPE OF WORK, Section 6.5.6.5, Member's Right to Confidentiality, subsection (B), is amended to read:

B. Contractor shall counsel Members on their right to confidentiality and Contractor shall obtain Member's consent prior to release of confidential information, unless such consent is not required pursuant to Title 22, CCR, Section 51009.

101. Article VI, SCOPE OF WORK, Section 6.5.7.8, Sensitive Services, paragraph one, is amended to read:

Contractor shall implement and maintain procedures to ensure confidentiality and ready access to Sensitive Services for all Members, including minors. Members shall be able to access Sensitive Services in a timely manner and without barriers such as Prior Authorization requirements. Access to abortion services for Members who are minors shall be subject to applicable state and federal law.

102. Article VI, SCOPE OF WORK, Section 6.5.8.4, Member Medical Record, sentence one, is amended to read:

Contractor shall ensure that a complete Medical Record shall be maintained for each Member in accordance with Title 22, CCR, Section 53861, and it shall reflect all aspects of patient care, including ancillary services, and at a minimum shall include:

103. Article VI, SCOPE OF WORK, is amended by adding a new Section 6.5.10.7, Targeted Case Management Services, to read as follows:

6.5.10.7 TARGETED CASE MANAGEMENT SERVICES

If a Member is receiving targeted case management services as defined in Title 22, CCR, Section 51185(h) and as specified in Title 22, CCR, Section 51351, Contractor shall be responsible for coordinating the Member's health care with the targeted case management provider and for determining the medical necessity of diagnostic and treatment services recommended by the targeted case management provider that are Covered Services under the Contract.

104. Article VI, SCOPE OF WORK, Section 6.6.6, Provider to Member Ratios, is amended to read:

6.6.6 PROVIDER TO MEMBER RATIOS

A. Contractor shall ensure that networks continuously satisfy the following full time equivalent provider to Member ratios:

1.	Primary Care Physicians	1:2,000
2.	Total Physicians	1:1,200

B. If Non-Physician Medical Practitioners are included in Contractor's provider network, each individual Non-Physician Medical Practitioner shall not exceed a full-time equivalent provider/patient caseload of one provider per 1,000 patients.

105. Article VI, SCOPE OF WORK, Section 6.6.7, Physician Supervisor to Non-Physician Medical Practitioner Ratios, subsection (D), is amended to read:

D. Four (4) Non-Physician Medical Practitioners in any combination that does not include more than three nurse midwives or two physician assistants.

106. Article VI, SCOPE OF WORK, Section 6.6.8, Subcontracts, is amended to read:

6.6.8 SUBCONTRACTS

Contractor shall execute Subcontracts pursuant to the requirements contained in Article III, Section 3.28, Subcontracts and Title 22, CCR, Section 53867.

107. Article VI, SCOPE OF WORK, Section 6.6.13, Monthly Report, is amended to read:

6.6.13 QUARTERLY REPORT

Contractor shall submit to DHS on a quarterly basis, in a format specified by DHS, a report summarizing changes in the provider network. The report shall identify provider deletions and additions and the resulting impact to: 1) geographic access for the Members; 2) cultural and linguistic services; 3) the targeted percentage of traditional and safety-net providers; 4) the ethnic composition of providers; and 5) the number of Members assigned to Primary Care Physicians and the percentage of Members assigned to traditional and safety-net providers. Contractor shall submit the report thirty (30) days following the end of the reporting quarter.

108. Article VI, SCOPE OF WORK, Section 6.6.14, Contract and Employment Terminations, is amended to read:

6.6.14 CONTRACT AND EMPLOYMENT TERMINATIONS

Contractor shall ensure that the composition of Contractor's provider network meets the ethnic, cultural, and linguistic needs of Contractor's Members on a continuous basis.

109. Article VI, SCOPE OF WORK, Section 6.6.15, Utilization of DSH Hospitals, is amended to read:

6.6.15 UTILIZATION OF DSH HOSPITALS

Contractor shall increase Utilization of Disproportionate Share Hospitals (DSH) by Members to a level specified by DHS upon notification. DHS shall only impose this requirement if the Utilization of DSH has decreased in such magnitude as to jeopardize DSH supplemental payments in the county.

110. Article VI, SCOPE OF WORK, Section 6.6.17, Emergency Service Providers, is amended to read:

6.6.17 EMERGENCY SERVICE PROVIDERS

A. Contractor shall pay for Emergency Services received by a Member from non-Contractor providers. Payments to non-Contractor providers shall be for the treatment of the Emergency Medical Condition including Medically Necessary services rendered to a Member until the Member's condition has stabilized sufficiently to permit discharge, or referral and transfer in accordance with instructions from Contractor. Emergency Services shall not be subject to Prior Authorization by Contractor.

B. Contractor shall pay for those services provided by a non-Contractor emergency department (ED) that are required to determine whether treatment of the Member's condition qualifies as an Emergency Service, including, at a minimum, a medical screening examination to determine the presence or absence of an Emergency Medical Condition. At a minimum, Contractor must reimburse the non-Contractor ED and, if applicable, its affiliated providers for Physician services at the lowest level of evaluation and management CPT (Physician's Current Procedural Terminology) codes, unless a higher level is clearly supported by documentation, and for the Facility fee and diagnostic services such as laboratory and radiology.

C. Payment by Contractor, or by a subcontractor who is at risk for out-of-plan Emergency Services, for properly documented claims for services rendered by a non-Contractor provider pursuant to this section shall be made in accordance with Article III, Section 3.28.9, Payment, and shall not exceed the lower of the following rates applicable at the time the services were rendered by the provider:

1. The usual charges made to the general public by the provider.

2. The maximum Fee-For-Service rates for similar services under the Medi-Cal program.

3. The rate agreed to by Contractor and the provider.

D. For inpatient services, reimbursement by Contractor, or by a subcontractor that is at risk for out-of-plan Emergency Services, to an out-of-plan Emergency Services provider shall be the lower of the following rates applicable to the provider at the time the services were rendered by the provider:

1. For a provider not contracting with the State under the Selected Provider Contracting Program, the lower of:

   a. The Medi-Cal Fee-For-Service rate that would be received by the provider if the service were provided for a beneficiary under the Medi-Cal Fee-For-Service program; or

   b. The inpatient rate negotiated by Contractor or subcontractor with the provider.

2. For a provider contracting with the State under the Selected Provider Contracting Program, the lower of:

   a. The average California Medical Assistance Commission (CMAC) rate for the geographic region, referred to as Standard Consolidated Statistical Area, in which the provider is located, for the last year reported, as published in the most recent CMAC Annual Report to the Legislature; or

   b. The inpatient rate negotiated by Contractor or subcontractor with the provider.

E. Disputed Emergency Services claims may be submitted to DHS for resolution under the provisions of Section 14454, W&I Code and Title 22, CCR, Section 53875. Contractor agrees to abide by the findings of DHS in such cases, to promptly reimburse the non-Contractor provider within 30 days of the effective date of a decision that Contractor is liable for payment of a claim and to provide proof of reimbursement in such form as the Director may require. Failure to reimburse the non-Contractor provider and provide proof of reimbursement to DHS within 30 days shall result in liability offsets in accordance with Title 22, CCR, Section 53875.

111. Article VI, SCOPE OF WORK, Section 6.6.20, FQHC Services, paragraph one, is amended to read as follows:

6.6.20 FQHC SERVICES

Contractor shall meet federal requirements for access and reimbursement for FQHC services, including those in 42 United States Code Section 1396 b(m) and Medicaid Regional Memorandum 93-13. If FQHC services are not available in the provider network of either Medi-Cal managed care contractor in the county, Contractor shall reimburse FQHCs for services provided out-of-plan to Contractor's Members at the interim FQHC rate determined by DHS. If FQHC services are not available in Contractor's provider network, but are available within DHS' time and distance standards for access to Primary Care for Contractor's Members in the other Medi-Cal managed care contractor's provider network in the county, Contractor shall not be obligated to reimburse FQHCs for services provided out-of-plan to Members (unless authorized by Contractor).

112. Article VI, SCOPE OF WORK, Section 6.6.21, FQHC Subcontracts is amended to read:

6.6.21 FQHC AND RURAL HEALTH CLINICS (RHC) CONTRACTS

A. Notwithstanding Article III, Section 3.28.4, Department Approval - Federally Qualified HMOs, Contractor shall not enter into any contract with an FQHC or RHC for provision of Covered Services to Members without prior written approval by DHS. All contracts with FQHCs or RHCs shall provide reimbursement to the FQHC or RHC on the basis of each center's or clinic's Medi-Cal interim per visit rate, applicable on the date the reimbursable services were provided, as established by DHS, unless:

1. DHS has approved in writing an alternate reimbursement methodology; or

2. The FQHC or RHC agrees to be reimbursed on an at-risk basis and such agreement is contained in the contract with the center or clinic. In contracts where a negotiated rate is agreed to as total payment, the contract shall state that such payment constitutes total payment to the entity.

B. To the extent that Indian Health Service facilities qualify as FQHCs or RHCs, the same reimbursement requirements shall apply to contracts with Indian Health Service facilities.

113. Article VI, SCOPE OF WORK, Section 6.6.22, Indian Health Service Facilities, is amended to read:

6.6.22 INDIAN HEALTH SERVICES FACILITIES

Contractor shall reimburse out-of-plan Indian Health Service Facilities for services provided to Members who are qualified to receive services from an Indian Health Service Facility. Contractor shall reimburse the out-of-plan Indian Health Service Facility at the approved Medi-Cal rate for that Facility.

The contract requirements in Section 6.6.21, FQHC and Rural Health Clinic Contracts, shall apply to any Indian Health Service Facility which is also an FQHC or RHC.

114. Article VI, SCOPE OF WORK, Section 6.7.1.1, General Requirements, is amended to read:

6.7.1.1 GENERAL REQUIREMENTS

Contractor shall provide or arrange for all Medically Necessary Covered Services for Members. Covered Services are those services set forth in Title 22, CCR, Chapter 3, Article 4, beginning with Section 51301, and Title 17, CCR, Division 1, Chapter 4, Subchapter 13, beginning with Section 6840, unless otherwise specifically excluded under the terms of this Contract. Contractor shall ensure that the medical necessity of Covered Services is determined through Utilization control procedures established in accordance with Sections 6.5.9.3, Pre-Authorization/Review Procedures, and 6.5.9.4, Exceptions to Prior Authorization Requirement, unless specific Utilization control requirements are included as terms of the Contract under sections applicable to specific services. However, no Utilization control procedure, or any other policy or procedure used by Contractor, shall limit services Contractor is required to provide under this Contract.

115. Article VI, SCOPE OF SERVICES, Section 6.7.2.2, Waiver Programs, is amended to read:

6.7.2.2 WAIVER PROGRAMS

Contractor shall maintain systems for identifying and referring Members to the appropriate waiver program, including the In-Home Medical Care Waiver Program, the Skilled Nursing Facility Waiver Program, the Model Waiver Program, the Acquired Immune Deficiency (AIDS) and AIDS Related Conditions Waiver Program, and the Multipurpose Senior Services Waiver Program. If the agency administering the waiver program concurs with Contractor's assessment of the Member and there is available placement in the waiver program, Contractor shall initiate Disenrollment for the Member. Contractor shall provide documentation to ensure the Member's orderly transfer to the Medi-Cal Fee-For-Service program. If the Member does not meet the criteria for the waiver program, or if placement is not available, Contractor shall continue to case manage and provide all Medically Necessary Covered Sservices to the Member.

116. Article VI, SCOPE OF WORK, Section 6.7.3.1, Miscellaneous Service Carve Outs, is amended to read:

6.7.3.1 MISCELLANEOUS SERVICE CARVE OUTS

Acupuncture services, adult day health care services, chiropractic services, and healing by prayer or spiritual means are not Covered Services under this Contract. Contractor may, upon request, refer Members to these services.

Local Education Agency (LEA) assessment services provided to any student and any LEA services provided pursuant to an Individual Education Plan (IEP) or Individual Family Service Plan (IFSP) or Individualized Health and Support Plan (IHSP) are not covered under the Contract.

Childhood lead poisoning case management is not a Covered Service under this Contract. Laboratories subcontracting with Contractor shall refer Members with elevated blood lead levels to the Childhood Lead Poisoning Prevention Branch of DHS which, in turn, shall provide this information to the Local Health Department. The Local Health Department shall coordinate case information and care with the Primary Care Physician.

117. Article VI, SCOPE OF WORK, Section 6.7.3.2, CCS Services, is amended to read:

6.7.3.2 CALIFORNIA CHILDREN SERVICES (CCS)

A. Contractor shall develop and implement written policies and procedures for identifying and referring children with CCS-eligible conditions to the local CCS program. The policies and procedures shall include, but not be limited to:

1. Policies and operational controls that assure that Contractor's providers perform appropriate baseline health assessments and diagnostic evaluations that provide sufficient clinical detail to establish, or raise a reasonable suspicion, that a Member child has a CCS-eligible medical condition;

2. Procedures for assuring that Contracting Providers are informed about CCS-paneled providers and CCS-approved hospitals within Contractor's network; and

3. Procedures for initial referrals of Member children with CCS-eligible conditions to the local CCS program by telephone, same-day mail or FAX, if available. The initial referral shall be followed by submission of supporting medical documentation sufficient to allow for eligibility determination by the local CCS program.

4. Procedures that provide for continuity of care between Contractor's providers and CCS providers for Member children determined eligible for the CCS program.

B. Contractor shall consult and coordinate CCS referral activities with the local CCS program in accordance with the agreement reached under a Memorandum of Agreement (MOA) between Contractor and LHD for coordination of CCS services.

C. Contractor shall continue to provide all Medically Necessary Covered Services and case management services for Member children referred to CCS until eligibility for the CCS program is established. Eligibility for the CCS program includes confirmation by the local CCS program of a Member child's CCS-eligible condition and agreement by the local CCS program to assume case management responsibilities for the Member child.

D. Once eligibility for the CCS program is established for a Member child:

1. Contractor shall continue to provide Primary Care and other Medically Necessary Covered Services unrelated to the CCS-eligible condition and will ensure the coordination of services between its Primary Care providers, the CCS specialty providers, and the local CCS program.

2. The CCS program shall authorize Medi-Cal payments to Contractor network physicians who currently are members of the CCS panel and to other providers who provided CCS-covered services to the Member child during the CCS-eligibility determination period and are determined to meet the CCS standards in accordance with subsection E. Authorization for payment shall be retroactive to the date the CCS program was informed about the Member child through an initial referral by Contractor or a Contractor network physician, via telephone, FAX, or mail. In an emergency admission, Contractor or Contractor network physician shall be allowed until the next business day to inform the CCS program about the Member child. Authorization shall be issued upon confirmation of panel status or completion of the process described in subsection E. Payment shall be dependent on the submittal of appropriately completed and timely claims to the local CCS program, which authorizes care. Claims authorized by the local CCS program shall be forwarded to the Medi-Cal Fee-For-Service program fiscal intermediary for payment.

E A board-certified physician who is a member of Contractor's provider network shall be determined to meet the CCS standards for participation as a CCS provider and shall be added to the CCS panel when all the following conditions are met:

1. The physician has successfully met Contractor's Credentialing standards;

2. The physician meets the CCS certification standards in accordance with Title 22, CCR, Sections 42320, 42321, 42336;

3. Contractor has submitted to the CCS program either a completed provider Credentialing application form used by Contractor or the information continued in lines one through five of the CCS Panel Application Form, extracted from Contractor's provider Credentialing application form for the physician;

4. Contractor has submitted to the CCS program a signed and dated CCS Panel Application Form with the Medi-Cal provider number for the physician.

For a physician who is board-eligible at the time of completion of Contractor's Credentialing application, Contractor must submit a completed provider Credentialing application form and a signed and dated CCS Panel Application Form, including the provider's Medi-Cal number.

The application of such a physician to the CCS panel will be retroactive to the extent necessary to enable the physician to receive payment for services on or after the date the CCS program was informed about the Member child, as provided in subsection D.2.

118. Article VI, SCOPE OF WORK, Section 6.7.3.3, Mental Health, is amended to read:

6.7.3.3 MENTAL HEALTH

All Specialty Mental Health Services (inpatient and outpatient) are excluded from the Contract.

A. Contractor shall provide outpatient mental health services within the Primary Care Physician's scope of practice. Contractor shall provide assistance to Members needing Specialty Mental Health Services by referring such Members, whose mental health diagnosis is covered by the local Medi-Cal mental health plan or whose diagnosis is uncertain, to the local Medi-Cal mental health plan, if operational. If the Medi-Cal mental health plan is not operational or if the Member's diagnosis is not covered by the local Medi-Cal mental health plan, Contractor shall refer such Members to an appropriate fee-for-service Medi-Cal mental health provider accepting Medi-Cal patients, if known to the Contractor, or shall refer such Members to the County Mental Health Department, or other community resources that may be able to assist the Member to locate mental health services, including the local CHDP program, regional centers for the developmentally disabled, and provider referral services.

B. Contractor shall provide Medical Case Management and cover and pay for all Medically Necessary Covered Services for the Member, including the services listed below, and coordinate services with the Specialty Mental Health Provider.

1. Emergency room professional services as described in Title 22, CCR, Section 53855, except psychiatrists, psychologists, licensed clinical social workers, marriage, family and child counselors, or other Specialty Mental Health Providers;

2. Facility charges for emergency room visits which do not result in a psychiatric admission;

3. All laboratory, radiological and radioisotope services when these services are necessary for the diagnosis, monitoring, or treatment of a Member's mental health condition.

4. Emergency medical transportation services necessary to provide access to all Medi-Cal covered services, including emergency mental health services, as described in Title 22, CCR, Section 51323.

5. All non-emergency medical transportation services, as provided for in Title 22, CCR, Section 51323, required by Members to access Medi-Cal covered mental health services, subject to a written prescription by a Medi-Cal Specialty Mental Health Provider, except when the transportation is required to transfer the Member from one facility to another, for the purpose of reducing the local Medi-Cal mental health plan's cost of providing services.

6. Medically Necessary Covered Services for Members admitted to a psychiatric inpatient hospital, including the initial health history and physical assessment required upon admission and any consultations related to Medically Necessary Covered Services. However, notwithstanding this requirement, Contractor shall not be responsible for room and board charges for psychiatric inpatient hospital stays by Members.

7. All Medically Necessary Medi-Cal covered psychotherapeutic drugs for Members not otherwise excluded under this Contract.

   a. This includes reimbursement for covered psychotherapeutic drugs prescribed by out-of-plan psychiatrists for Members.

b. If Contractor requires that covered prescriptions written by out-of-plan psychiatrists be filled by pharmacies in Contractor's provider network, Contractor shall ensure that drugs prescribed by out-of-plan psychiatrists are no less accessible to Members than drugs prescribed by network providers.

c. Reimbursement to pharmacies for those psychotherapeutic drugs listed in Attachment III (consisting of one page), and psychotherapeutic drugs classified as Anti-Psychotics and approved by the FDA after July 1, 1997, shall be made by DHS through the Medi-Cal FFS program, whether these drugs are provided by a pharmacy contracting with Contractor or by an out-of-plan pharmacy provider. To qualify for reimbursement under this provision, a pharmacy must be enrolled as a Medi-Cal provider in the Medi-Cal FFS program.

8. Paragraphs 3,5, and 6 shall not be construed to preclude Contractor from: a) requiring that Covered Services be provided through Contractor's provider network or b) applying Utilization controls for these services, including Prior Authorization, consistent with Contractor's obligation to provide Covered Services under this Contract.

C. Contractor shall execute a Memorandum of Understanding (MOU), in accordance with Section 6.7.9, Local Mental Health Plan Coordination, for coordination of Specialty Mental Health Services with the local Medi-Cal mental health plan in each county that is covered by this Contract.

D. Disputes between Contractor and the local Medi-Cal mental health plan regarding this section shall be resolved pursuant to Title 9, CCR, Section 1850.505. Any decision rendered by DHS and the California Department of Mental Health regarding a dispute between Contractor and the local Medi-Cal mental health plan concerning provision of mental health services or Covered Services required under this Contract shall not be subject to the Disputes and Appeals procedures specified in Article III, Section 3.22.

119. Article VI, SCOPE OF WORK, Section 6.7.3.4, Alcohol and Drug Treatment Services, sentence one, is amended to read:

Alcohol and drug treatment services available under the Short-Doyle Drug Medi-Cal program as defined in Title 22, CCR, Section 51341.1 and outpatient heroin detoxification as defined in Title 22, CCR, Section 51328 are excluded from this Contract.

120. Article VI, SCOPE OF WORK, Section 6.7.3.5, Dental, is amended to read:

6.7.3.5 DENTAL

Dental services are not covered under this Contract. Contractor shall perform dental screening for all Members as a part of the initial health assessment and refer Members to Medi-Cal dental providers. Dental screenings for Members under twenty-one (21) years of age shall be performed in accordance with the most recent recommendations of the American Academy of Pediatrics, as part of the initial health assessment. Contractor shall ensure referrals to dental providers.

Services related to dental services that are covered medical services and are not provided by dentists or dental anesthetists, are the responsibility of Contractor. Covered medical services include: prescription drugs, laboratory services, pre-admission physical examinations required for admission to a facility, anesthesia services, out-patient surgical center services and in-patient hospitalization services required for a dental procedure. Contractor may require Prior Authorization for medical services required in support of dental procedures.

Contractor shall develop referral and Prior Authorization policies and procedures to implement the above requirements. Contractor shall submit these policies and procedures to DHS for review and approval.

121. Article VI, SCOPE OF WORK, Section 6.7.3.7, Direct Observed Therapy (DOT) for Treatment of Tuberculosis, section title only, is amended to read:

6.7.3.7 DIRECTLY OBSERVED THERAPY (DOT) FOR TREATMENT OF TUBERCULOSIS

122. Article VI, SCOPE OF WORK, Section 6.7.4.3, School Linked CHDP Services: Subcontracts, is amended to read:

6.7.4.3 SCHOOL LINKED CHDP SERVICES: SUBCONTRACTS

Contractor shall ensure that the Subcontracts with the local school districts or school sites meet the requirements of Article III, Section 3.28, Subcontracts, and address the following: the population covered, beginning and end dates of the agreement, services covered, practitioners covered, outreach, information dissemination and educational responsibilities, Utilization Review requirements, referral procedures, medical information flows, patient information confidentiality, Quality Assurance interface, data reporting requirements, Grievances and complaint procedures.

123. Article VI, SCOPE OF WORK, Section 6.7.4.4, Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Supplemental Services, Excluding Case Management Services, is amended to read:

6.7.4.4 EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) SUPPLEMENTAL SERVICES, INCLUDING CASE MANAGEMENT SERVICES

For Members under the age of 21 years, Contractor shall provide or arrange and pay for EPSDT supplemental services as defined in Title 22, CCR, Section 51184, except when EPSDT supplemental services are provided as CCS services pursuant to Section 6.7.3.2, CCS Services, or as mental health services pursuant to Section 6.7.3.3, Mental Health. Contractor shall determine the medical necessity of EPSDT supplemental services using the criteria established in Title 22, CCR, Sections 51340 and 51340.1.

For Members under the age of 21 years, who meet the medical necessity criteria for EPSDT case management, pursuant to Title 22, CCR, Section 51340(f), Contractor shall refer the Member to a targeted case management (TCM) provider under contract with a local government agency pursuant to Welfare and Institutions Code Section 14132.44 or to entities and organizations, including Regional Centers, that provide TCM services pursuant to Welfare and Institutions Code Section 14132.48. If EPSDT case management services are rendered by these referral providers, Contractor is not required to pay for the EPSDT case management services. If EPSDT case management services are not available from these referral providers, Contractor shall provide or arrange and pay for the EPSDT case management services.

124. Article VI, SCOPE OF WORK, Section 6.7.4.7, Family Planning: Out-of-Network Reimbursement, is amended to read:

6.7.4.7 FAMILY PLANNING: OUT-OF-NETWORK REIMBURSEMENT

Contractor shall reimburse out-of-network family planning providers for the following services provided to Members of childbearing age to temporarily or permanently prevent or delay pregnancy:

A. Health education and counseling necessary to make informed choices and understand contraceptive methods.

B. Limited history and physical examination.

C. Laboratory tests if medically indicated as part of decision making process for choice of contraceptive methods. Contractor shall not be required to reimburse out-of-plan providers for pap smears if Contractor has provided pap smears to meet the U.S. Preventive Services Task Force guidelines.

D. Diagnosis and treatment of STD disease episode, as defined by DHS for each STD, if medically indicated.

E. Screening, testing and counseling of at risk individuals for HIV and referral for treatment.

F. Follow-up care for complications associated with contraceptive methods provided or prescribed by the family planning provider.

G. Provision of contraceptive pills, devices, supplies.

H. Tubal ligation.

I. Vasectomies.

J. Pregnancy testing and counseling.

125. Article VI, SCOPE OF WORK, Section 6.7.4.8, Family Planning: Reimbursement Rate, is amended to read:

6.7.4.8 FAMILY PLANNING: REIMBURSEMENT RATE

Contractor shall reimburse out-of-plan family planning providers at the appropriate Medi-Cal FFS rate, unless otherwise negotiated with the out-of-plan family planning provider.

126. Article VI, SCOPE OF WORK, Section 6.7.4.9, Sexually Transmitted Diseases (STDs), is amended to read:

6.7.4.9 SEXUALLY TRANSMITTED DISEASES (STDS)

Contractor shall provide access to STD services without Prior Authorization to all Members both within and outside its provider network. Members may access out-of-plan STD services through local health department (LHD) clinics, family planning clinics, or- through other community STD service providers. LHD and family planning providers shall be reimbursed for STD services pursuant to Sections 6.7.8.1, Subcontract, and 6.7.4.7, Family Planning: Out-Of-Network Reimbursement. For community providers other than LHD and family planning providers, the reimbursement of out-of-plan STD services is limited to one office visit per disease episode for the purposes of: (1) diagnosis and treatment of vaginal discharge and urethral discharge, (2) those STDs that are amenable to immediate diagnosis and treatment, and this includes syphilis, gonorrhea, chlamydia, herpes simplex, chancroid, Trichomoniasis, human papilloma virus, non-gonococcal urethritis, lymphogranuloma venereum and granuloma inguinale and (3) evaluation and treatment of Pelvic Inflammatory Disease (PID). Contractor shall provide follow-up care. Contractor shall reimburse STD providers at the Medi-Cal Fee-For-Service (FFS) rate, unless otherwise negotiated, and Contractor shall provide reimbursement only if STD treatment providers provide treatment records or documentation of the Member's refusal to release Medical Records to Contractor along with billing information.

127. Article VI, SCOPE OF WORK, Section 6.7.4.10, Early Intervention Services, sentence one, is amended to read:

Contractor shall refer to the local Early Start program those children in need of early intervention services, e.g., those with an established condition leading to developmental delay, those in whom a significant developmental delay is suspected, or those whose early health history places them at risk for delay.

128. Article VI, SCOPE OF WORK, Section 6.7.4.14, Nurse Midwife Services, is amended to read:

6.7.4.14 NURSE MIDWIFE AND NURSE PRACTITIONER SERVICES

Contractor shall meet federal requirements for access and reimbursement for Certified Nurse Midwife (CNM) services as defined in Title 22, CCR, Section 51345 and Certified Nurse Practitioner (CNP) services as defined in Title 22, CCR, Section 51345.1. If Members do not have access to CNM or CNP services within the provider network of either Medi-Cal managed care contractor in the county, Contractor shall inform Members that they have a right to obtain out-of-plan CNM or CNP services, and Contractor shall reimburse CNMs or CNPs for services provided out-of-plan to Members at the applicable Medi-Cal Fee-For-Service rates. If CNM services are unavailable in Contractor's provider network, but are available within DHS' time and distance standards for access to Primary Care in the other Medi-Cal managed care contractor's provider network in the county, Contractor shall not be obligated to reimburse CNMs for services provided out-of-plan to Members (unless authorized by Contractor). (This provision shall apply equally to CNP services.)

Notwithstanding the above paragraph, for Emergency Services and family planning, the provisions of Sections 6.6.16, Emergency Service Providers, 6.7.4.5, Family Planning: General Requirement, and 6.7.4.8, Family Planning: Reimbursement Rate, shall apply.

129. Article VI, SCOPE OF WORK, Section 6.7.6.1, Initial Health Assessment, sentence three, is amended to read:

For Members under the age of 21 years, the assessment shall follow the applicable requirements of Health and Safety Code, Section 124025, et seq., and Title 17, Sections 6840 through 6850, except that Contractor shall follow the most recent periodicity schedule recommended by the American Academy of Pediatrics.

130. Article VI, SCOPE OF WORK, Section 6.7.6.2, Children, paragraph one, is amended to read:

Contractor shall maintain and operate a system which ensures the provision of CHDP services to Members under the age of 21 years in accordance with the applicable provisions of the Health and Safety Code, Section 124025, et seq., and Title 17, CCR, Sections 6840 through 6850. The system shall include the following components:

131. Article VI, SCOPE OF WORK, Section 6.7.6.3, Pregnant Women: Minimum Standards, sentence two, is amended to read:

Contractor shall develop and implement standardized risk assessment tools which are consistent with Comprehensive Perinatal Services Program (CPSP) requirements set forth in Title 22, CCR, Sections 51348 and 51348.1.

132. Article VI, SCOPE OF WORK, Section 6.7.7.3, Behavioral Assessments, is amended to read:

6.7.7.3 INDIVIDUAL HEALTH EDUCATION BEHAVIORAL ASSESSMENTS

Contractor shall ensure that individual health education behavioral assessments are conducted on all Members within 120 days of Enrollment to determine health practices, values, behaviors, knowledge, attitudes, cultural practices, beliefs, literacy levels, and health education needs. Upon Contractor's written request, DHS may, at its discretion, delay Contractor implementation of this requirement. DHS shall approve any such request in writing. DHS may terminate any approved delay in implementation thirty (30) days after DHS' notice to Contractor of intent to terminate.

133. Article VI, SCOPE OF WORK, Section 6.7.7.7, Group Needs Assessment, is amended to read:

6.7.7.7 GROUP NEEDS ASSESSMENT

Contractor shall conduct a group needs assessment of its Members to determine health education needs, including literacy level. Contractor shall submit to DHS a report summarizing the methodology, findings, proposed services, key activities, timeline for implementation, and the responsible individuals. Contractor shall complete the needs assessment and submit the report to DHS between twelve (12) and eighteen (18) months after the commencement of operations under this Contract.

134. Article VI, SCOPE OF WORK, Section 6.7.8.1, Subcontract, paragraph 1, is amended to read:

Contractor shall execute a Subcontract for the specified public health services with the Local Health Department (LHD) in each county that is covered by this Contract. The Subcontract shall specify the scope and responsibilities of both parties, billing and reimbursements, reporting responsibilities, and Medical Record management to ensure coordinated health care services. The Subcontract shall meet the requirements contained

in Article III, Sections 3.28, Subcontracts, through 3.28.8, Disclosures. The specified public health services under the Subcontract are as follows:

135. Article VI, SCOPE OF WORK, Section 6.7.8.1, Subcontracts, subsection (B), is amended to read:

B. STD services for the disease episode, as defined by DHS for each STD, including diagnosis and treatment of the following STDs: syphilis, gonorrhea, chlamydia, herpes simplex, chancroid, trichomoniasis, human papilloma virus, non-gonococcal urethritis, lymphogranuloma venereum and granuloma inguinale.

136. Article VI, SCOPE OF WORK, Section 6.7.8.1, Subcontracts, subsection (H), is amended to read:

H. Tuberculosis Directly Observed Therapy

137. Article VI, SCOPE OF WORK, is amended by adding a new Section 6.7.9 to read:

6.7.9. LOCAL MENTAL HEALTH PLAN COORDINATION

6.7.9.1 MEMORANDUM OF UNDERSTANDING

A. Contractor shall negotiate in good faith and execute a Memorandum of Understanding (MOU) with the local mental health plan (MHP). The MOU shall specify, consistent with this Contract, the respective responsibilities of Contractor and the MHP in delivering Medically Necessary Covered Services and Specialty Mental Health Services to Members. The MOU shall address:

1. Protocols and procedures for referrals between Contractor and the MHP;

2. Protocols for the delivery of Specialty Mental Health Services, including the MHP's provision of clinical consultation to Contractor for Members being treated by Contractor for mental illness;

3. Protocols for the delivery of mental health services within the Primary Care Physician's scope of practice;

4. Protocols and procedures for the exchange of Medical Records information, including procedures for maintaining the confidentiality of Medical Records;

5. Procedures for the delivery of Medically Necessary Covered Services to Members who require Specialty Mental Health Services, including:

   a. Pharmaceutical services and prescription drugs;

   b. Laboratory, radiological and radioisotope services;

   c. Emergency room facility charges and professional services;

   d. Emergency and non-emergency medical transportation;

   e. Home health services;

   f. Medically Necessary Covered Services to Members who are patients in psychiatric inpatient hospitals.

6. Procedures for transfers between inpatient psychiatric services and inpatient medical services to address changes in a Member's medical or mental health condition.

7. Procedures to resolve disputes between Contractor and the MHP.

B. To the extent Contractor does not execute an MOU within four (4) months after implementation of the Medi-Cal Specialty Mental Health Services Consolidation program in the area being served by this Contract, Contractor shall submit documentation substantiating its good faith efforts to enter into an MOU. Until such time as an MOU is executed, Contractor shall submit monthly reports to DHS documenting its continuing good faith efforts to execute an MOU and the justifications why such an MOU has not been executed.

138. Article VI, SCOPE OF WORK, Section 6.8.1, Marketing Representatives, paragraph one, sentence one, is amended to read:

Contractor shall ensure, in addition to compliance with the requirements of Title 22, CCR, Section 53880, that:

139. Article VI, SCOPE OF WORK, Section 6.8.6, Marketing Plan, is amended to read:

6.8.6 MARKETING PLAN

Contractor shall implement and maintain a Marketing plan approved by DHS. Door to door Marketing is prohibited.

140. Article VI, SCOPE OF WORK, Section 6.9.3, Disclosure Forms, is amended to read:

6.9.3 DISCLOSURE FORMS

Contractor shall provide to all Members the Evidence of Coverage and Disclosure Form materials which constitute a fair disclosure of the provisions of the covered health care services.

141. Article VI, SCOPE OF WORK, Section 6.9.5, Membership Services Guide, is amended to read:

6.9.5 MEMBERSHIP SERVICES GUIDE

Contractor shall develop and distribute a Membership Services Guide that includes the following information:

A. The name, address and telephone number of the health plan.

B. A description of the full scope of Medi-Cal covered benefits and all available services including health education, interpretive services, and "carve out" services and an explanation of any service limitations and exclusions from coverage or charges for services.

C. Procedures for obtaining Covered Services including the address and telephone number of each Service Site (locations of hospitals, Primary Care Physicians, optometrists, psychologists, pharmacies, Skilled Nursing Facilities, Urgent Care Facilities). In the case of a medical foundation or independent practice association, the address and telephone number of each Physician provider.

   1. The hours and days when each of these Facilities is open, the services and benefits available, and the telephone number to call after normal business hours.

D. Procedures for selecting or requesting a change in Primary Care Physician, including requirements for a change in PCP; reasons for which a request may be denied; and reasons why a provider may request a change.

E. The purpose and value of scheduling an initial health assessment appointment.

F. The appropriate use of health care services in a managed care system.

G. The availability and procedures for obtaining after hours services (24-hour basis) and care, including the appropriate provider locations and telephone numbers.

H. Procedure for obtaining emergency health care both within and outside Contractor's Service Area.

I. Process for referral to specialists.

J. Procedures for obtaining any non-medical transportation services offered by Contractor and through the local CHDP programs, and how to obtain such services.

K. The causes for which a Member shall lose entitlement to receive services under this Contract. (See Article III, Section 3.23.5, Disenrollment)

L. Procedures for filing a complaint/Grievance, including procedures for appealing decisions regarding Member's coverage, benefits, or relationship to the organization. Include the title, address, and telephone number of the person responsible for processing and resolving complaints/Grievances.

M. Procedures for Disenrollment, including an explanation of the Member's right to disenroll without cause at any time, subject to any restricted disenrollment period.

N. Information on the Member's right to the Medi-Cal fair hearing process, regardless of whether or not a complaint/Grievance has been submitted or if the complaint/Grievance has been resolved, pursuant to Title 22, CCR, Section 53452, when a health care service requested by the Member or provider has been denied, deferred or modified. The State Department of Social Services' Public Inquiry and Response Unit toll free telephone number (800) 952-5253.

O. Information on the availability of, and procedures for obtaining, services at FQHCs and Indian Health Clinics.

P. Information on the Member's right to seek family planning services from any qualified provider of family planning services under the Medi-Cal program, including providers outside Contractor's provider network, and a description of those services, such as the following statement:

" Family planning services are provided to Members of child bearing age to enable them to determine the number and spacing of children. These services include all methods of birth control approved by the Federal Food and Drug Administration. As a Member, you pick a doctor who is located near you and will give you the services you need. Our Primary Care Physicians and OB/GYN specialists are available for family planning services. For family planning services, you may also pick a doctor or clinic not connected with Molina Medical Centers, Inc. without having to get permission from Molina Medical Centers, Inc. Molina Medical Centers, Inc. shall pay that doctor or clinic for the family planning services you get".

Q. DHS' Office of Family Planning's toll free telephone number (1-800-942-1054) providing consultation and referral to family planning clinics.

R. Any other information determined by DHS to be essential for the proper receipt of Covered Services.

S. Information on the availability of, and procedures for obtaining, Certified Nurse Midwife and Certified Nurse Practitioner services, pursuant to Section 6.7.4.14, Nurse Midwife and Nurse Practitioner Services.

T. Information on the availability of transitional Medi-Cal eligibility and how the Member may apply for this program. Contractor shall include this information with all Membership Service Guides sent to Members after the date such information is furnished to Contractor by DHS.

U. Information on how to access State resources for investigation and resolution of Member complaints, including the DHS Medi-Cal Managed Care Ombudsman toll-free telephone number (1-888-452-8609) and the DOC HMO Consumer Service toll-free telephone number (1-800-400-0815).

V. Information concerning the provision and availability of services covered under the CCS program from providers outside Contractor's provider network and how to access these services.

W. An explanation of the expedited disenrollment process for children receiving services under the Foster Care or Adoption Assistance Programs; Members with special health care needs, including, but not limited to major organ transplants; and Members already enrolled in another Medi-Cal, Medicare or commercial managed care plan.

X. Information on how to obtain Minor Consent Services through Contractor's plan, and an explanation of those services.

Y. A brief explanation on how to use the fee-for-service system when Medi-Cal covered services are excluded or limited under this Contract and how to obtain additional information.

Z. An explanation of an American Indian Member's right to access Indian Health Service facilities and to disenroll from Contractor's plan at any time, without cause.

AA. Subsections S through Z above, except subsection T, shall be included in Contractor's Membership Services Guide by April 1,1999, or upon the next reprinting of Contractor's Membership Services Guide, whichever is sooner.

142. Article VI SCOPE OF WORK, Section 6.9.9, Primary Care Physician Selection, is amended to read:

6.9.9 PRIMARY CARE PHYSICIAN SELECTION

Contractor shall implement and maintain DHS approved procedures to ensure that each new Member has an appropriate and available Primary Care Physician. Contractor shall provide each new Member an opportunity to select a Primary Care Physician within the first thirty (30) days of Enrollment. If Contractor's provider network includes nurse practitioners or certified nurse midwives, the Member may select a nurse practitioner or certified nurse midwife within thirty (30) days of enrollment to provide Primary Care services. Contractor shall ensure that Members are allowed to change a Primary Care Physician, nurse practitioner or certified nurse midwife, upon request, by selecting a different Primary Care Provider from Contractor's network of providers. Contractor shall

provide the Member sufficient information (verbal and written) in the appropriate language and reading level about the selection process and the available providers in the network, including certified nurse midwives and certified nurse practitioners, to ensure their ability to make an informed decision.

143. Article VI, SCOPE OF WORK, Section 6.9.10, Primary Care Physician Assignment, is amended to read:

6.9.10 PRIMARY CARE PHYSICIAN ASSIGNMENT

If the Member does not select a Primary Care Physician, nurse practitioner, or certified nurse midwife within thirty (30) days of the effective date of Enrollment, Contractor shall assign that Member to a Primary Care Physician and notify the Member and the assigned Primary Care Physician no later than forty (40) days after the Member's Enrollment. In all cases where a nurse practitioner or a certified nurse midwife is a Member's selected Primary Care Provider, Contractor shall assure that an individual Primary Care Physician is responsible for the overall coordination of the Member's health care, consistent with applicable State and federal laws and regulations. Contractor shall ensure that adverse selection does not occur during the assignment process of Members to providers.

144. Article VI, SCOPE OF WORK, Section 6.9.11, Continuity of Care, is amended to read:

6.9.11 CONTINUITY OF CARE

Contractor shall ensure that Members with an established relationship with a provider in Contractor's network, who have expressed a desire to continue their patient/provider relationship, are assigned to that provider without disruption in their care.

145. Article VI, SCOPE OF WORK, Section 6.9.13, Member Complaint/Grievance System, is amended to read:

6.9.13 MEMBER COMPLAINT/GRIEVANCE SYSTEM

Contractor shall implement and maintain a Member complaint/Grievance system in accordance with Title 10, CCR, Section 1300.68, except subsection 1300.68(g), and Title 22, CCR, Section 53858.

A. Contractor shall acknowledge receipt of a complaint within 5 days. The written acknowledgement shall also notify the complainant of a person at the plan who may be contacted regarding the complaint.

B. Contractor shall resolve the complaint within 30 days of receipt or document reasonable efforts to resolve the complaint within thirty (30) days of receipt.

146. Article VI, SCOPE OF WORK, Section 6.9.14, Disenrollments, is deleted.

147. Article VI, SCOPE OF WORK, Section 6.9.15, Denial, Deferral, or Modification of Prior Authorization Requests, is renumbered and amended to read:

6.9.15 DENIAL, DEFERRAL, OR MODIFICATION OF PRIOR AUTHORIZATION REQUESTS

A. Contractor shall notify Members of denial, deferral, or modification of requests for Prior Authorization, in accordance with Title 22, CCR, Sections 51014.1 and 53894 by providing written notification to Members and/or their authorized representative, regarding any denial, deferral or modification of a request for approval to provide a health care service. This notification must be provided as specified in Title 22, CCR, Sections 51014.1, 51014.2, and 53894.

B. Contractor shall provide for a written notification to the Member and the Member's representative on a standardized form approved by DHS, informing the Member of all the following:

1. The Member's right to, and method of obtaining, a fair hearing to contest the denial, deferral or modification action.

2. The Member's right to represent himself/herself at the fair hearing or to be represented by legal counsel, friend or other spokesperson.

3. The name and address of Contractor and the State toll-free telephone number for obtaining information on legal service organizations for representation.

C. The notice to the Member may inform the Member that the Member may file a complaint/Grievance concerning Contractor's action using Contractor's complaint/Grievance process prior to or concurrent with the initiation of the fair hearing process.

D. Contractor shall provide required notification to beneficiaries and the representatives in accordance with the time frames set forth in Title 22, CCR, Sections 51014.1 and 53894.

148. Article VI, SCOPE OF WORK, Section 6.10.2, Linguistic Services, subsection (B), paragraph (3), is amended to read:

3. Translated written materials, including the Membership Services Guide, enrollee information, welcome packets, and marketing information.

149. Article VI, SCOPE OF WORK, Section 6.10.6, Cultural and Linguistics Services Plan, is amended to read:

6.10.6 CULTURAL AND LINGUISTICS SERVICES PLAN

Contractor shall ensure that a group needs assessment of Members is completed between twelve (12) and eighteen (18) months after the commencement of operations under this Contract. This group needs assessment shall be conducted in conjunction with the health education group needs assessment, described in Section 6.7.7.7, Group Needs Assessment, and shall include identification of linguistic and cultural needs of the groups which speak a primary language other than English.

The findings of the assessment shall be submitted to DHS in the form of a plan entitled "Cultural and Linguistic Services Plan" between twelve (12) and eighteen (18) months after commencement of operations under this Contract. In the plan, Contractor shall summarize the methodology, and findings of the group needs assessment of cultural and linguistic needs of non-English-speaking groups, and outline the proposed services to be implemented to address the findings of cultural and linguistic needs of non-English-speaking Members, the timeline for implementation with milestones, and the responsible individual.

Contractor shall ensure implementation of the Cultural and Linguistic Services Plan between twelve (12) and eighteen (18) months after the commencement of operations under this Contract. Contractor shall also identify the individual with overall responsibility for the activities to be conducted under the plan. DHS approval of the plan is required prior to its implementation.

150. Article VI, SCOPE OF WORK, Section 6.11.1, Time Frames, is amended to read:

6.11.1 TIME FRAMES

Contractor shall submit deliverables within the timeframes specified on the Implementation Plan approved by DHS. Compliance with the schedule is mandatory unless otherwise approved in writing by DHS. (See Article III, Section 3.18, Liquidated Damages Provisions). Unless otherwise specified, all completion dates listed for the deliverables are calculated from the Contract effective date.

151. Attachment 1 is amended by adding the following language to the capitation rate sheets:

The State is entering into this capitated Contract as an alternative means of paying for medical care for members of the eligible Medi-Cal population. The traditional payment method, called Fee-For-Service, requires Medi-Cal beneficiaries to find an authorized Medi-Cal provider when they are in need of health care. The State reimburses these Medi-Cal providers for services rendered, according to an established schedule of fees. Under this capitated Contract, the State pays Contractor a monthly fee for each Medi-Cal beneficiary enrolled in its prepaid health plan, and Contractor is then responsible for providing all medically necessary health care services to the beneficiary as required by the Contract.

The rate development process for this Contract consists of two separate calculations. First, a Fee-For-Service equivalent (FFSE) is determined for the entire group of Medi-Cal eligibles. Second, rates are calculated for each Contract by beneficiary aid code using historical Medi-Cal managed care data. The name given this latter method is an experienced based methodology. Both the FFSE and experience based methodologies use factors which directly influence the cost of providing health care to Medi-Cal beneficiaries. These factors are age, sex, geographic area with price indices, Medi-Cal aid code, and eligibility for Medicare. The rate methodologies also employ adjustments for changes that are likely to occur during the term of the Contract. These adjustments include fee, benefit, or policy changes to reflect changes to the Medi-Cal program that are mandated each year by the State Legislature and the use of a trend factor to project costs to the term of the Contract.

Actuaries employed by the Department of Health Services conduct the rate development process for this Contract. This attachment presents the methodology and calculation of the capitation rates for this Contract.

152. The effective date of the following amendments shall be the date of approval by the Department of Finance of this amendment package: 28, 41, 56, 59, 62, 64, 66, 67, 69, 70, 72, 75, 89, 90, 91, 106, 113, 116, 117, 119, 122, 127, 131, 136, 138, 140, 141, 147.

153. The effective date of the following amendments is January 1, 1999: 61, 65, 84, 92, 109.

154. The effective date of the all other amendments in this package shall be October 1, 1997.

155. The effective date of the rate adjustment shall be October 1,1997.

156. All rights, duties, obligations and liabilities of the parties hereto otherwise remain unchanged.

Plan Name: Molina Medical Center
Plan Number: 355
Plan Type: Commercial Plan
County: Riverside
Aid Code Grouping: Family

Date: 12-Aug-98
Base Period: FY 95/96

The Rate Period is October 1, 1997 to September 30, 1998
Capitation Payments at the Beginning of the Month
Stop Loss Reinsurance has not been elected
CCS indicated claims are not covered
Eye appliances are provided by PIA
The plan is not responsible for Mental Health services
The plan is responsible for Long Term Care Services in the month of admission
and the next month only
The plan provides CHDP Services

	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	FQHC	Total
1. Base Units per Eligible	4.127	4.686	0.263	2.139	0.002	3.495	0.120	
2. Eligibility Adjustment	1.014	0.998	1.045	1.026	1.000	0.995	1.000	
3. Age/sex Adjustment	1.028	0.987	1.045	1.012	1.000	1.006	1.000	
Adjusted Units	4.302	4.616	0.287	2.221	0.002	3.498	0.120	
4. Average Cost Per Unit	$ 67.40	$ 16.48	940.29	$ 17.95	$ 115.00	$ 22.23	$ 64.52	$ 1,243.87
5. Area Adjustment	1.048	1.000	1.000	1.000	1.000	1.000	1.000	
Adjusted Cost	$ 70.64	$ 16.48	$ 940.29	$ 17.95	$ 115.00	$ 22.23	$ 64.52	$ 1,247.11
6. Contract Adjustments								
a.Mental Health	0.978	0.995	1.000	0.955	0.994	0.919	0.949	
b.Long Term Care	1.000	1.000	1.000	1.000	0.335	1.000	1.000	
c.Procedure Adjs.	0.999	1.000	1.000	1.000	1.000	0.913	1.000	
d.	1.000	1.000	1.000	1.000	1.000	1.000	1.000	
7. Interest Adjustment	0.995	0.995	0.995	0.995	0.995	0.995	0.995	
Contract Cost per Eligible	$ 295.43	$ 75.31	$ 268.51	$ 37.88	$ 0.08	$ 64.92	$ 7.31	$ 749.44
8. Legislative Adjustment	1.026	1.052	0.993	1.004	1.038	1.027	1.027	
9. Trend Adjustments								
a.Cost per Unit	1.036	1.146	1.048	0.967	1.123	1.046	1.000	
b.Units per Eligible	0.950	1.100	0.998	1.045	1.000	1.050	1.000	
Projected Cost per Eligible	$ 298.32	$ 99.87	$ 278.87	$ 38.43	$ 0.09	$ 73.23	$ 7.51	$ 796.32
Preliminary Monthly Rate								$ 66.36
10. Stop Loss Reinsurance			$ 0			0.0%		0.00
11. CHDP								4.60
12.								0.00
13. Fee-for-Service Adjustment						6.6%		4.69
14. FQHC County Cost Differential								0.26
Capitation Rate								$ 75.91

Plan Name: Molina Medical Center
Plan Number: 355
Plan Type: Commercial Plan
County: Riverside
Aid Code Grouping: Aged

Date: 12-Aug-98
Base Period: FY 95/96

The Rate Period is October 1, 1997 to September 30, 1998
Capitation Payments at the Beginning of the Month
Stop Loss Reinsurance has not been elected
CCS indicated claims are not covered
Eye appliances are provided by PIA
The plan is not responsible for Mental Health services
The plan is responsible for Long Term Care Services in the month of admission and the next month only
The plan provides CHDP Services

	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	FQHC	Total
1. Base Units per Eligible	3.770	19.658	0.982	2.464	0.554	13.308	0.120	
2. Eligibility Adjustment	0.960	1.017	0.959	0.979	1.002	1.021	1.000	
3. Age/sex Adjustment	0.989	1.002	1.005	0.990	1.043	1.008	1.000	
Adjusted Units	3.579	20.032	0.946	2.388	0.579	13.696	0.120	
4. Average Cost Per Unit	$ 47.81	$ 30.45	889.66	$ 10.85	$ 69.41	$ 5.85	$ 43.50	$ 1,097.53
5. Area Adjustment	1.048	1.000	1.000	1.000	1.000	1.000	1.000	
Adjusted Cost	$ 50.10	$ 30.45	$ 889.66	$ 10.85	$ 69.41	$ 5.85	$ 43.50	$ 1,099.82
6. Contract Adjustments								
a.Mental Health	0.991	0.996	1.000	0.986	0.996	0.958	0.989	
b.Long Term Care	1.000	1.000	1.000	1.000	0.196	1.000	1.000	
c.Procedure Adjs.	0.990	1.000	1.000	1.000	1.000	0.799	1.000	
d.	1.000	1.000	1.000	1.000	1.000	1.000	1.000	
7. Interest Adjustment	0.995	0.995	0.995	0.995	0.995	0.995	0.995	
Contract Cost per Eligible	$ 175.04	$ 604.50	$ 837.41	$ 25.42	$ 7.81	$ 61.02	$ 5.14	$ 1,716.34
8. Legislative Adjustment	1.004	1.033	0.907	0.917	1.038	1.001	1.001	
9. Trend Adjustments								
a.Cost per Unit	0.865	1.105	1.079	1.036	1.034	1.049	1.000	
b.Units per Eligible	0.950	1.050	1.050	1.100	1.000	1.045	1.000	
Projected Cost per Eligible	$ 144.41	$ 724.52	$ 860.51	$ 26.56	$ 8.38	$ 66.96	$ 5.15	$ 1,836.49
Preliminary Monthly Rate								$ 153.04
10. Stop Loss Reinsurance			$ 0			0.0%		0.00
11. CHDP								0.00
12.								0.00
13. Fee-for-Service Adjustment						6.0%		9.18
14. FQHC County Cost Differential								0.07
Capitation Rate								$ 162.29

Plan Name: Molina Medical Center
Plan Number: 355
Plan Type: Commercial Plan
County: Riverside
Aid Code Grouping: Disabled

Date: 12-Aug-98
Base Period: FY 95/96

The Rate Period is October 1, 1997 to September 30, 1998
Capitation Payments at the Beginning of the Month
Stop Loss Reinsurance has not been elected
CCS indicated claims are not covered
Eye appliances are provided by PIA
The plan is not responsible for Mental Health services
The plan is responsible for Long Term Care Services in the month of admission
and the next month only
The plan provides CHDP Services

	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	FQHC	Total
1. Base Units per Eligible	6.559	24.089	1.155	4.742	0.176	20.858	0.240	
2. Eligibility Adjustment	0.996	1.005	1.000	0.999	0.996	1.007	1.000	
3. Age/sex Adjustment	0.995	0.989	0.985	0.999	1.009	0.996	1.000	
Adjusted Units	6.500	23.943	1.138	4.733	0.177	20.920	0.240	
4. Average Cost Per Unit	$ 45.69	$ 35.66	867.73	$ 13.05	$ 100.13	$ 9.33	$ 72.26	$ 1,143.85
5. Area Adjustment	1.048	1.000	1.000	1.000	1.000	1.000	1.000	
Adjusted Cost	$ 47.88	$ 35.66	$ 867.73	$ 13.05	$ 100.13	$ 9.33	$ 72.26	$ 1,146.04
6. Contract Adjustments								
a.Mental Health	0.894	0.882	1.000	0.972	0.994	0.949	0.909	
b.Long Term Care	1.000	1.000	1.000	1.000	0.099	1.000	1.000	
c.Procedure Adjs.	0.998	0.997	1.000	1.000	1.000	0.918	1.000	
d.	1.000	1.000	1.000	1.000	1.000	1.000	1.000	
7. Interest Adjustment	0.995	0.995	0.995	0.995	0.995	0.995	0.995	
Contract Cost per Eligible	$ 276.29	$ 747.04	$ 982.54	$ 59.74	$ 1.74	$ 169.19	$ 15.69	$ 2,252.23
8. Legislative Adjustment	1.010	1.034	0.908	0.918	1.039	1.007	1.007	
9. Trend Adjustments								
a.Cost per Unit	0.954	1.161	1.032	0.977	1.042	1.032	1.000	
b.Units per Eligible	0.950	1.050	0.950	1.050	1.000	0.998	1.000	
Projected Cost per Eligible	$ 252.91	$ 941.64	$ 874.66	$ 56.26	$ 1.88	$ 175.47	$ 15.80	$ 2,318.62
Preliminary Monthly Rate								$ 193.22
10. Stop Loss Reinsurance			$ 0			0.0%		0.00
11. CHDP								0.00
12.								0.00
13. Fee-for-Service Adjustment						6.0%		11.59
14. FQHC County Cost Differential								0.15
Capitation Rate								$ 204.96

Plan Name: Molina Medical Center
Plan Number: 355
Plan Type: Commercial Plan
County: Riverside
Aid Code Grouping: Child

Date: 12-Aug-98

Base Period: FY 95/96

The Rate Period is October 1, 1997 to September 30, 1998
Capitation Payments at the Beginning of the Month
Stop Loss Reinsurance has not been elected
CCS indicated claims are not covered
Eye appliances are provided by PIA
The plan is not responsible for Mental Health services
The plan is responsible for Long Term Care Services in the month of admission
and the next month only
The plan provides CHDP Services

	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	FQHC	Total
1. Base Units per Eligible	3.962	3.669	0.332	1.521	0.000	2.012	0.120	
2. Eligibility Adjustment	1.005	1.017	1.021	1.020	1.000	1.077	1.000	
3. Age/sex Adjustment	1.201	0.992	1.294	1.101	1.000	1.112	1.000	
Adjusted Units	4.782	3.702	0.439	1.708	0.000	2.410	0.120	
4. Average Cost Per Unit	$ 65.30	$ 11.46	965.53	$ 17.74	$ 0.00	$ 24.55	$ 60.59	$ 1,145.17
5. Area Adjustment	1.048	1.000	1.000	1.000	1.000	1.000	1.000	
Adjusted Cost	$ 68.43	$ 11.46	$ 965.53	$ 17.74	$ 0.00	$ 24.55	$ 60.59	$ 1,148.30
6. Contract Adjustments								
a.Mental Health	0.976	0.989	1.000	0.974	0.993	0.911	0.982	
b.Long Term Care	1.000	1.000	1.000	1.000	0.140	1.000	1.000	
c.Procedure Adjs.	0.999	1.000	1.000	1.000	1.000	0.917	1.000	
d.	1.000	1.000	1.000	1.000	1.000	1.000	1.000	
7. Interest Adjustment	0.995	0.995	0.995	0.995	0.995	0.995	0.995	
Contract Cost per Eligible	$ 317.46	$ 41.75	$ 421.75	$ 29.36	$ 0.00	$ 49.18	$ 7.10	$ 866.60
8. Legislative Adjustment	1.026	1.052	0.993	1.004	1.038	1.023	1.023	
9. Trend Adjustments								
a.Cost per Unit	0.967	1.085	1.024	0.933	1.178	1.091	1.000	
b.Units per Eligible	0.950	1.050	0.950	1.045	1.000	1.100	1.000	
Projected Cost per Eligible	$ 299.22	$ 50.04	$ 407.41	$ 28.74	$ 0.00	$ 60.38	$ 7.26	$ 853.05
Preliminary Monthly Rate								$ 71.09
10. Stop Loss Reinsurance			$ 0			0.0%		0.00
11. CHDP								3.46
12.								0.00
13. Fee-for-Service Adjustment						6.0%		4.47
14. FQHC County Cost Differential								0.31
Capitation Rate								$ 79.33

Plan Name: Molina Medical Center
Plan Number: 355
Plan Type: Commercial Plan
County: Riverside
Aid Code Grouping: Adult

Date: 12-Aug-98
Base Period: FY 95/96

The Rate Period is October 1, 1997 to September 30, 1998
Capitation Payments at the Beginning of the Month
Stop Loss Reinsurance has not been elected
CCS indicated claims are not covered
Eye appliances are provided by PIA
The plan is not responsible for Mental Health services
The plan is responsible for Long Term Care Services in the month of admission
and the next month only
The plan provides CHDP Services

	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	FQHC	Total
1. Base Units per Eligible	21.372	5.536	3.082	4.726	0.000	12.855	0.240	
2. Eligibility Adjustment	1.000	1.000	1.000	1.000	1.000	1.000	1.000	
3. Age/sex Adjustment	1.000	1.000	1.000	1.000	1.000	1.000	1.000	
Adjusted Units	21.372	5.536	3.082	4.726	0.000	12.855	0.240	
4. Average Cost Per Unit	$ 100.08	$ 16.10	998.85	$ 15.92	$ 0.00	$ 37.45	$ 54.29	$ 1,222.69
5. Area Adjustment	1.048	1.000	1.000	1.000	1.000	1.000	1.000	
Adjusted Cost	$ 104.88	$ 16.10	$ 998.85	$ 15.92	$ 0.00	$ 37.45	$ 54.29	$ 1,227.49
6. Contract Adjustments								
a.Mental Health	0.999	0.999	1.000	0.991	1.000	0.997	0.996	
b.Long Term Care	1.000	1.000	1.000	1.000	1.000	1.000	1.000	
c.Procedure Adjs.	1.000	1.000	1.000	1.000	1.000	0.867	1.000	
d.	1.000	1.000	1.000	1.000	1.000	1.000	1.000	
7. Interest Adjustment	0.995	0.995	0.995	0.995	0.995	0.995	0.995	
Contract Cost per Eligible	$ 2,228.06	$ 88.60	$ 3,063.06	$ 74.19	$ 0.00	$ 414.06	$ 12.91	$ 5,880.88
8. Legislative Adjustment	1.022	1.052	0.993	1.004	1.038	1.023	1.023	
9. Trend Adjustments								
a.Cost per Unit	0.961	1.162	1.023	0.886	1.015	1.096	1.000	
b.Units per Eligible	0.950	0.998	1.000	1.155	1.000	0.950	1.000	
Projected Cost per Eligible	$ 2,078.86	$ 108.09	$ 3,111.58	$ 76.22	$ 0.00	$ 441.03	$ 13.21	$ 5,828.99
Preliminary Monthly Rate								$ 485.75
10. Stop Loss Reinsurance			$ 0			0.0%		0.00
11. CHDP								0.00
12.								0.00
13. Fee-for-Service Adjustment						6.0%		29.15
14. FQHC County Cost Differential								0.77
Capitation Rate								$ 515.67

Plan Name: Molina Medical Center
Plan Number: 355
Plan Type: Commercial Plan
County: Riverside
Aid Code Grouping: AIDS

Date: 12-Aug-98
Base Period: FY 95/96

The Rate Period is October 1, 1997 to September 30, 1998
Capitation Payments at the Beginning of the Month
Stop Loss Reinsurance has not been elected
CCS indicated claims are not covered
Eye appliances are provided by PIA
The plan is not responsible for Mental Health services
The plan is responsible for Long Term Care Services in the month of admission
and the next month only
The plan provides CHDP Services

	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	FQHC	Total
1. Base Units per Eligible	22.646	65.596	3.118	7.972	0.000	39.287	0.360	
2. Eligibility Adjustment	1.000	1.000	1.000	1.000	1.000	1.000	1.000	
3. Age/sex Adjustment	1.000	1.000	1.000	1.000	1.000	1.000	1.000	
Adjusted Units	22.646	65.596	3.118	7.972	0.000	39.287	0.360	
4. Average Cost Per Unit	$ 31.10	$ 92.80	867.73	$ 19.90	$ 0.00	$ 50.87	$ 72.26	$ 1,134.66
5. Area Adjustment	1.048	1.000	1.000	1.000	1.000	1.000	1.000	
Adjusted Cost	$ 32.59	$ 92.80	$ 867.73	$ 19.90	$ 0.00	$ 50.87	$ 72.26	$ 1,136.15
6. Contract Adjustments								
a.Mental Health	0.934	0.990	1.000	0.993	1.000	0.988	0.959	
b.Long Term Care	1.000	1.000	1.000	1.000	0.456	1.000	1.000	
c.Procedure Adjs.	1.000	0.819	1.000	1.000	1.000	0.592	1.000	
d.Viral Testing	1.000	1.082	1.000	1.000	1.000	1.000	1.000	
7. Interest Adjustment	0.995	0.995	0.995	0.995	0.995	0.995	0.995	
Contract Cost per Eligible	$ 685.88	$ 5,313.67	$ 2,692.05	$ 156.74	$ 0.00	$ 1,163.09	$ 24.82	$ 10,036.25
8. Legislative Adjustment	1.004	1.073	0.993	1.004	1.038	1.001	1.001	
9. Trend Adjustments								
a.Cost per Unit	0.954	1.161	1.032	0.977	1.042	1.032	1.000	
b.Units per Eligible	0.903	1.045	0.950	0.950	1.000	1.045	1.000	
Projected Cost per Eligible	$ 593.22	$ 6,917.40	$ 2,620.81	$ 146.06	$ 0.00	$ 1,255.58	$ 24.84	$ 11,557.91
Preliminary Monthly Rate								$ 963.16
10. Stop Loss Reinsurance			$ 0			0.0%		0.00
11. CHDP								0.00
12.								0.00
13. Fee-for-Service Adjustment						6.0%		57.79
14. FQHC County Cost Differential								0.54
Capitation Rate								$ 1,021.49

Plan Name: Molina Medical Center
Plan Number: 356
Plan Type: Commercial Plan
County: San Bernardino
Aid Code Grouping: Family

Date: 12-Aug-98
Base Period: FY 95/96

The Rate Period is October 1, 1997 to September 30, 1998
Capitation Payments at the Beginning of the Month
Stop Loss Reinsurance has not been elected
CCS indicated claims are not covered
Eye appliances are provided by PIA
The plan is not responsible for Mental Health services
The plan is responsible for Long Term Care Services in the month of admission
and the next month only
The plan provides CHDP Services

	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	FQHC	Total
1. Base Units per Eligible	4.127	4.686	0.263	2.139	0.002	3.495	0.120	
2. Eligibility Adjustment	0.987	0.994	0.967	0.985	1.000	0.982	1.000	
3. Age/sex Adjustment	1.016	0.995	1.026	1.010	1.000	1.005	1.000	
Adjusted Units	4.139	4.635	0.261	2.128	0.002	3.449	0.120	
4. Average Cost Per Unit	$ 67.40	$ 16.48	1,023.54	$ 17.95	$ 115.00	$ 22.23	$ 64.52	$ 1,327.12
5. Area Adjustment	1.048	1.000	1.000	1.000	1.000	1.000	1.000	
Adjusted Cost	$ 70.64	$ 16.48	$ 1,023.54	$ 17.95	$ 115.00	$ 22.23	$ 64.52	$ 1,330.36
6. Contract Adjustments								
a.Mental Health	0.978	0.995	1.000	0.955	0.994	0.919	0.949	
b.Long Term Care	1.000	1.000	1.000	1.000	0.335	1.000	1.000	
c.Procedure Adjs.	0.999	1.000	1.000	1.000	1.000	0.913	1.000	
d.	1.000	1.000	1.000	1.000	1.000	1.000	1.000	
7. Interest Adjustment	0.995	0.995	0.995	0.995	0.995	0.995	0.995	
Contract Cost per Eligible	$ 284.23	$ 75.62	$ 265.81	$ 36.30	$ 0.08	$ 64.01	$ 7.31	$ 733.36
8. Legislative Adjustment	1.026	1.052	0.993	1.004	1.038	1.027	1.027	
9. Trend Adjustments								
a.Cost per Unit	1.036	1.146	1.048	0.967	1.123	1.046	1.000	
b.Units per Eligible	0.950	1.100	0.998	1.045	1.000	1.050	1.000	
Projected Cost per Eligible	$ 287.01	$ 100.28	$ 276.07	$ 36.83	$ 0.09	$ 72.20	$ 7.51	$ 779.99
Preliminary Monthly Rate								$ 65.00
10. Stop Loss Reinsurance			$ 0			0.0%		0.00
11. CHDP								4.60
12.								0.00
13. Fee-for-Service Adjustment						6.0%		4.18
14. FQHC County Cost Differential								0.26
Capitation Rate								$ 74.04

Plan Name: Molina Medical Center   Date: 12-Aug-98
Plan Number: 356
Plan Type: Commercial Plan   Base Period: FY 95/96
County: San Bernardino
Aid Code Grouping: Aged

The Rate Period is October 1, 1997 to September 30, 1998
Capitation Payments at the Beginning of the Month
Stop Loss Reinsurance has not been elected
CCS indicated claims are not covered
Eye appliances are provided by PIA
The plan is not responsible for Mental Health services
The plan is responsible for Long Term Care Services in the month of admission
and the next month only
The plan provides CHDP Services

	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	FQHC	Total
1. Base Units per Eligible	3.770	19.658	0.982	2.464	0.554	13.308	0.120	
2. Eligibility Adjustment	0.969	1.014	0.965	0.985	1.000	1.015	1.000	
3. Age/sex Adjustment	0.987	1.002	0.995	0.990	1.032	1.005	1.000	
Adjusted Units	3.606	19.973	0.943	2.403	0.572	13.575	0.120	
4. Average Cost Per Unit	$ 47.81	$ 30.45	952.39	$ 10.85	$ 69.41	$ 5.85	$ 43.50	$ 1,160.26
5. Area Adjustment	1.048	1.000	1.000	1.000	1.000	1.000	1.000	
Adjusted Cost	$ 50.10	$ 30.45	$ 952.39	$ 10.85	$ 69.41	$ 5.85	$ 43.50	$ 1,162.55
6. Contract Adjustments								
a.Mental Health	0.991	0.996	1.000	0.986	0.996	0.958	0.989	
b.Long Term Care	1.000	1.000	1.000	1.000	0.196	1.000	1.000	
c.Procedure Adjs.	0.990	1.000	1.000	1.000	1.000	0.799	1.000	
d.	1.000	1.000	1.000	1.000	1.000	1.000	1.000	
7. Interest Adjustment	0.995	0.995	0.995	0.995	0.995	0.995	0.995	
Contract Cost per Eligible	$ 176.36	$ 602.72	$ 893.61	$ 25.58	$ 7.71	$ 60.48	$ 5.14	$ 1,771.60
8. Legislative Adjustment	1.004	1.033	0.907	0.917	1.038	1.001	1.001	
9. Trend Adjustments								
a.Cost per Unit	0.865	1.105	1.079	1.036	1.034	1.049	1.000	
b.Units per Eligible	0.950	1.050	1.050	1.100	1.000	1.045	1.000	
Projected Cost per Eligible	$ 145.50	$ 722.38	$ 918.26	$ 26.73	$ 8.28	$ 66.36	$ 5.15	$ 1,892.66
Preliminary Monthly Rate								$ 157.72
10. Stop Loss Reinsurance			$ 0			0.0%		0.00
11. CHDP								0.00
12.								0.00
13. Fee-for-Service Adjustment						6.0%		9.46
14. FQHC County Cost Differential								0.07
Capitation Rate								$ 167.25

Plan Name: Molina Medical Center
Plan Number: 356
Plan Type: Commercial Plan
County: San Bernardino
Aid Code Grouping: Disabled

Date: 12-Aug-98

Base Period: FY 95/96

The Rate Period is October 1, 1997 to September 30, 1998
Capitation Payments at the Beginning of the Month
Stop Loss Reinsurance has not been elected
CCS indicated claims are not covered
Eye appliances are provided by PIA
The plan is not responsible for Mental Health services
The plan is responsible for Long Term Care Services in the month of admission
and the next month only
The plan provides CHDP Services

	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	FQHC	Total
1. Base Units per Eligible	6.679	24.089	1.155	4.742	0.176	20.858	0.120	
2. Eligibility Adjustment	0.995	1.001	0.976	0.991	0.999	0.996	1.000	
3. Age/sex Adjustment	0.998	0.976	0.981	1.006	1.003	0.993	1.000	
Adjusted Units	6.632	23.534	1.106	4.728	0.176	20.629	0.120	
4. Average Cost Per Unit	$ 45.69	$ 35.66	1,064.73	$ 13.05	$ 100.13	$ 9.33	$ 72.26	$ 1,340.85
5. Area Adjustment	1.048	1.000	1.000	1.000	1.000	1.000	1.000	
Adjusted Cost	$ 47.88	$ 35.66	$ 1,064.73	$ 13.05	$ 100.13	$ 9.33	$ 72.26	$ 1,343.04
6. Contract Adjustments								
a.Mental Health	0.894	0.882	1.000	0.972	0.994	0.949	0.909	
b.Long Term Care	1.000	1.000	1.000	1.000	0.099	1.000	1.000	
c.Procedure Adjs.	0.998	0.997	1.000	1.000	1.000	0.918	1.000	
d.	1.000	1.000	1.000	1.000	1.000	1.000	1.000	
7. Interest Adjustment	0.995	0.995	0.995	0.995	0.995	0.995	0.995	
Contract Cost per Eligible	$ 281.90	$ 734.28	$ 1,171.70	$ 59.67	$ 1.73	$ 166.84	$ 7.84	$ 2,423.96
8. Legislative Adjustment	1.010	1.034	0.908	0.918	1.039	1.007	1.007	
9. Trend Adjustments								
a.Cost per Unit	0.954	1.161	1.032	0.977	1.042	1.032	1.000	
b.Units per Eligible	0.950	1.050	0.950	1.050	1.000	0.998	1.000	
Projected Cost per Eligible	$ 258.04	$ 925.56	$ 1,043.05	$ 56.19	$ 1.87	$ 173.04	$ 7.89	$ 2,465.64
Preliminary Monthly Rate								$ 205.47
10. Stop Loss Reinsurance			$ 0			0.0%		0.00
11. CHDP								0.00
12.								0.00
13. Fee-for-Service Adjustment						6.0%		12.33
14. FQHC County Cost Differential								0.07
Capitation Rate								$ 217.87

Plan Name: Molina Medical Center
Plan Number: 356
Plan Type: Commercial Plan
County: San Bernardino
Aid Code Grouping: Child

Date: 12-Aug-98
Base Period: FY 95/96

The Rate Period is October 1, 1997 to September 30, 1998
Capitation Payments at the Beginning of the Month
Stop Loss Reinsurance has not been elected
CCS indicated claims are not covered
Eye appliances are provided by PIA
The plan is not responsible for Mental Health services
The plan is responsible for Long Term Care Services in the month of admission
and the next month only
The plan provides CHDP Services

	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	FQHC	Total
1. Base Units per Eligible	3.962	3.669	0.332	1.521	0.000	2.012	0.120	
2. Eligibility Adjustment	1.019	1.003	1.034	1.026	1.000	1.021	1.000	
3. Age/sex Adjustment	1.168	1.009	1.237	1.095	1.000	1.072	1.000	
Adjusted Units	4.716	3.713	0.425	1.709	0.000	2.202	0.120	
4. Average Cost Per Unit	$ 65.30	$ 11.46	1,022.12	$ 17.74	$ 0.00	$ 24.55	$ 60.59	$ 1,201.76
5. Area Adjustment	1.048	1.000	1.000	1.000	1.000	1.000	1.000	
Adjusted Cost	$ 68.43	$ 11.46	$ 1,022.12	$ 17.74	$ 0.00	$ 24.55	$ 60.59	$ 1,204.89
6. Contract Adjustments								
a.Mental Health	0.976	0.989	1.000	0.974	0.993	0.911	0.982	
b.Long Term Care	1.000	1.000	1.000	1.000	0.140	1.000	1.000	
c.Procedure Adjs.	0.999	1.000	1.000	1.000	1.000	0.917	1.000	
d.	1.000	1.000	1.000	1.000	1.000	1.000	1.000	
7. Interest Adjustment	0.995	0.995	0.995	0.995	0.995	0.995	0.995	
Contract Cost per Eligible	$ 313.08	$ 41.87	$ 432.23	$ 29.38	$ 0.00	$ 44.93	$ 7.10	$ 868.59
8. Legislative Adjustment	1.026	1.052	0.993	1.004	1.038	1.023	1.023	
9. Trend Adjustments								
a.Cost per Unit	0.967	1.085	1.024	0.933	1.178	1.091	1.000	
b.Units per Eligible	0.950	1.050	0.950	1.045	1.000	1.100	1.000	
Projected Cost per Eligible	$ 295.09	$ 50.18	$ 417.53	$ 28.76	$ 0.00	$ 55.16	$ 7.26	$ 853.98
Preliminary Monthly Rate								$ 71.17
10. Stop Loss Reinsurance			$ 0			0.0%		00.00
11. CHDP								3.46
12.								0.00
13. Fee-for-Service Adjustment						6.0%		4.48
14. FQHC County Cost Differential								0.31
Capitation Rate								$ 79.42

Plan Name: Molina Medical Center
Plan Number: 356
Plan Type: Commercial Plan
County: San Bernardino
Aid Code Grouping: Adult

Date: 12-Aug-98

Base Period: FY 95/96

The Rate Period is October 1, 1997 to September 30, 1998
Capitation Payments at the Beginning of the Month
Stop Loss Reinsurance has not been elected
CCS indicated claims are not covered
Eye appliances are provided by PIA
The plan is not responsible for Mental Health services
The plan is responsible for Long Term Care Services in the month of admission
and the next month only
The plan provides CHDP Services

	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	FQHC	Total
1. Base Units per Eligible	21.492	5.536	3.082	4.726	0.000	12.855	0.120	
2. Eligibility Adjustment	1.000	1.000	1.000	1.000	1.000	1.000	1.000	
3. Age/sex Adjustment	1.000	1.000	1.000	1.000	1.000	1.000	1.000	
Adjusted Units	21.492	5.536	3.082	4.726	0.000	12.855	0.120	
4. Average Cost Per Unit	$ 100.08	$ 16.10	1,055.89	$ 15.92	$ 0.00	$ 37.45	$ 54.29	$ 1,279.73
5. Area Adjustment	1.048	1.000	1.000	1.000	1.000	1.000	1.000	
Adjusted Cost	$ 104.88	$ 16.10	$ 1,055.89	$ 15.92	$ 0.00	$ 37.45	$ 54.29	$ 1,284.53
6. Contract Adjustments								
a.Mental Health	0.999	0.999	1.000	0.991	1.000	0.997	0.996	
b.Long Term Care	1.000	1.000	1.000	1.000	1.000	1.000	1.000	
c.Procedure Adjs.	1.000	1.000	1.000	1.000	1.000	0.867	1.000	
d.	1.000	1.000	1.000	1.000	1.000	1.000	1.000	
7. Interest Adjustment	0.995	0.995	0.995	0.995	0.995	0.995	0.995	
Contract Cost per Eligible	$ 2,240.57	$ 88.60	$ 3,237.98	$ 74.19	$ 0.00	$ 414.06	$ 6.46	$ 6,061.86
8. Legislative Adjustment	1.022	1.052	0.993	1.004	1.038	1.023	1.023	
9. Trend Adjustments								
a.Cost per Unit	0.961	1.162	1.023	0.886	1.015	1.096	1.000	
b.Units per Eligible	0.950	0.998	1.000	1.155	1.000	0.950	1.000	
Projected Cost per Eligible	$ 2,090.53	$ 108.09	$ 3,289.27	$ 76.22	$ 0.00	$ 441.03	$ 6.61	$ 6,011.75
Preliminary Monthly Rate								$ 500.98
10. Stop Loss Reinsurance			$ 0			0.0%		0.00
11. CHDP								0.00
12.								0.00
13. Fee-for-Service Adjustment						6.0%		30.06
14. FQHC County Cost Differential								0.38
Capitation Rate								$ 531.42

Plan Name: Molina Medical Center
Plan Number: 356
Plan Type: Commercial Plan
County: San Bernardino
Aid Code Grouping: AIDS

Date: 12-Aug-98

Base Period: FY 95/96

The Rate Period is October 1, 1997 to September 30, 1998
Capitation Payments at the Beginning of the Month
Stop Loss Reinsurance has not been elected
CCS indicated claims are not covered
Eye appliances are provided by PIA
The plan is not responsible for Mental Health services
The plan is responsible for Long Term Care Services in the month of admission and the next month only
The plan provides CHDP Services

	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	FQHC	Total
1. Base Units per Eligible	22.886	65.596	3.118	7.972	0.000	39.287	0.120	
2. Eligibility Adjustment	1.000	1.000	1.000	1.000	1.000	1.000	1.000	
3. Age/sex Adjustment	1.000	1.000	1.000	1.000	1.000	1.000	1.000	
Adjusted Units	22.886	65.596	3.118	7.972	0.000	39.287	0.120	
4. Average Cost Per Unit	$ 31.10	$ 92.80	1,064.73	$ 19.90	$ 0.00	$ 50.87	$ 72.26	$ 1,331.66
5. Area Adjustment	1.048	1.000	1.000	1.000	1.000	1.000	1.000	
Adjusted Cost	$ 32.59	$ 92.80	$ 1,064.73	$ 19.90	$ 0.00	$ 50.87	$ 72.26	$ 1,333.15
6. Contract Adjustments								
a.Mental Health	0.934	0.990	1.000	0.993	1.000	0.988	0.959	
b.Long Term Care	1.000	1.000	1.000	1.000	0.456	1.000	1.000	
c.Procedure Adjs.	1.000	0.819	1.000	1.000	1.000	0.592	1.000	
d.Viral Testing	1.000	1.082	1.000	1.000	1.000	1.000	1.000	
7. Interest Adjustment	0.995	0.995	0.995	0.995	0.995	0.995	0.995	
Contract Cost per Eligible	$ 693.15	$ 5,313.67	$ 3,303.23	$ 156.74	$ 0.00	$ 1,163.09	$ 8.27	$ 10,638.15
8. Legislative Adjustment	1.004	1.073	0.993	1.004	1.038	1.001	1.001	
9. Trend Adjustments								
a.Cost per Unit	0.954	1.161	1.032	0.977	1.042	1.032	1.000	
b.Units per Eligible	0.903	1.045	0.950	0.950	1.000	1.045	1.000	
Projected Cost per Eligible	$ 599.51	$ 6,917.40	$ 3,215.82	$ 146.06	$ 0.00	$ 1,255.58	$ 8.28	$ 12,142.65
Preliminary Monthly Rate								$ 1,011.89
10. Stop Loss Reinsurance			$ 0			0.0%		0.00
11. CHDP								0.00
12.								0.00
13. Fee-for-Service Adjustment						6.0%		60.71
14. FQHC County Cost Differential								0.18
Capitation Rate								$ 1,072.78

STATE OF CALIFORNIA

STANDARD AGREEMENT -- APPROVED BY THE ATTORNEY GENERAL
STD. 2(REV 5-91)

CONTRACT NUMBER 95-23637 AM. NO. 04
TAXPAYER'S FEDERAL ID NO. 33-0342719

THIS AGREEMENT, made and entered into this 15th day of August, 1999 in the State of California, by and between State of California, through its duly elected or appointed, qualified and acting

TITLE OF OFFICER ACTING FOR STATE
Chief, Program Support Branch

AGENCY
Department of Health Services, hereafter called the State, and

CONTRACTOR'S NAME
MOLINA, hereafter called the Contractor.

WTTNESSETH: That the Contractor for and in consideration of the covenants, conditions, agreements, and stipulations of the State hereinafter expressed, Does hereby agree to furnish to the State services and materials as follows: (Set forth services to be rendered by Contractor, amount to be paid Contractor, Time for performance or completion, and attach plans and specifications, if any.)

ARTICLE I - PREAMBLE

Amendment A04 to Contract No.95-23637 BETWEEN MOLINA MEDICAL CENTERS, INC., AND THE STATE OF CALIFORNIA;

WHEREAS, the State of California and Molina Medical Centers, Inc., entered into a contract to provide health care services to Medi-Cal beneficiaries dated April 2, 1996; and

NOW THEREFORE, this Contract is amended as follows:

CONTINUED ON 1 SHEETS, EACH BEARING NAME OF CONTRACTOR AND CONTRACT NUMBER.

The provisions on the reverse side hereof constitute a part of this agreement. IN WITNESS WHEREOF, this agreement has been executed by the parties hereto, upon the date first above written.

STATE OF CALIFORNIA	CONTRACTOR
AGENCY Department of Health Services	CONTRACTOR (if other than an individual, state whether a corporation, partnership, etc.) Molina
BY (AUTHORIZED SIGNATURE) /s/ Jayna Querin for	BY (AUTHORIZED SIGNATURE) /s/
PRINTED NAME OF PERSON SIGNING Edward E. Stahlberg JAYNA QUERIN CHIEF CONTRACT MANAGEMENT UNIT	PRINTED NAME OF AND TITLE OF PERSON SIGNING George Goldstein, President
TITLE Chief, Program Support Branch	ADDRESS One Golden Shore, Long Beach, CA 90802

AMOUNT ENCUMBERED BY THIS DOCUMENT $ 0	PROGRAM/CATEGORY (CODE AND TITLE) Loc.Asst.Section 14157, W&I Code		FUND TITLE Health Care Deposit		Department of General Services Use Only
	(OPTIONAL USE)				
PRIOR AMOUNT ENCUMBERED FOR THIS CONTRACT $ 420,053,310	ITEM 4260-601-912	CHAPTER 50	STATUTE 1999	FISCAL YEAR 99/00	Exempt From PCC per W&I Code Section 14087.4
TOTAL AMOUNT ENCUMBERED TO DATE $ 420,053,310	OBJECT OF EXPENDITURE (CODE AND TITLE) 9912-705-95915				
I hereby certify upon my own personal knowledge that budgeted funds are available for the period and purpose of the expenditure stated above.	T.B.A. NO.	I.R. NO.			
SIGNATURE OF ACCOUNTING OFFICER /s/ Sharon Flaherty	DATE 08/30/99				

[ ] CONTRACTOR [ ] STATE AGENCY [ ] DEPT. OF GEN. SER. [ ] CONTROLLER [ ]

STATE OF CALIFORNIA
STANDARD AGREEMENT
STD. 2 (REV. 5-91)(REVERSE)

1. The contractor agrees to indemnify, defend and save harmless the State, its officers, agents and employees from any and all claims and losses accruing or resulting to any and all contractors, subcontractors, materialmen, laborers and any other person, firm or corporation furnishing or supplying work services, materials or supplies in connection with the performance of this contract, and from any and all claims and losses accruing or resulting to any person, firm or corporation who may be injured or damaged by the Contractor in the performance of this contract.

2. The Contractor, and the agents and employees of Contractor, in the performance of the agreement, shall act in an independent capacity and not as officers or employees or agents of State of California.

3. The State may terminate this agreement and be relieved of the payment of any consideration to Contractor should Contractor fail to perform the covenants herein contained at the time and in the manner herein provided. In the event of such termination, the State may proceed with the work in any manner deemed proper by the State. The cost to the state shall be deducted from any sum due the Contractor under this agreement, and the balance, if any, shall be paid the Contractor upon demand.

4. Without the written consent of the State, this agreement is not assignable by Contractor either in whole or in part.

5. Time is of the essence in this agreement.

6. No alteration or variation of the terms of this contract shall be valid unless made in writing and signed by the parties hereto, and no oral understanding or agreement not incorporated herein, shall be binding on any of the parties hereto.

7. The consideration to be paid Contractor, as provided herein, shall be in compensation for all of Contractor's expenses incurred in the performance hereof, including travel and per diem, unless otherwise expressly so provided.

1. ARTICLE III - GENERAL TERMS AND CONDITIONS, Section 3.15 Term, paragraph two, is amended to read:

   3.15 TERM

   The term of the Contract consists of the following three periods: 1) The Implementation Period shall extend from March 1,1996 to June 1,1996; 2) The Operations Period shall extend from June 1,1996 to March 1,2002, subject to the termination provisions of Sections 3.18, Termination and 3.19, Sanctions, and subject to the limitation provisions of Article V, Payment Provisions, Section 5.2, Amounts Payable; and 3) The Turnover/Phaseout Period shall extend for six (6) months from the end of the Operations Period, subject to the provisions of Section 3.16, Contract Extension, in which case the Turnover/Phaseout shall apply to the six (6) month period beginning the first day after the end of the Operations Period, as extended.

2. The Contractor name, Molina Medical Centers, Inc., has been changed to Molina. Therefore, all references in this Contract to Molina Medical Centers, Inc shall be retitled as Molina.

3. The effective date of this Amendment shall be August 15,1999.

4. All rights, obligations, duties and Liabilities of the parties hereto otherwise remain unchanged.

CONTRACT NUMBER AM. NO.
95-23637 05

STANDARD AGREEMENT -- APPROVED BY THE ATTORNEY GENERAL
STD. 2(REV.5-91)

TAXPAYER'S FEDERAL ID NUMBER
33-0342719

THIS AGREEMENT, made and entered into this 1 day of September, 2000 in the State of California, by and between State of California, through its duly elected or appointed, qualified and acting

TITLE Of OFFICER ACTING FOR STATE
Chief, Program Support Branch

AGENCY
Department of Health Services, hereafter called the State, and

CONTRACTOR'S NAME
Molina, hereafter called the Contractor.

WITNESSETH: That the Contractor for and in consideration of the covenants, conditions, agreements, and stipulations of the State hereinafter expressed does hereby agree to furnish to the State services and materials as follows: (Set forth services to be rendered by Contractor, amount to be paid Contractor, time for performance or completion, and attach plans and specifications, if any.)

AMENDMENT A-05 TO CONTRACT NUMBER 95-23637 BETWEEN MOLINA AND THE STATE OF CALIFORNIA; AND

WHEREAS, the State of California and Molina entered into a Contract to provide health care services to Medi-Cal beneficiaries dated April 1, 1996, and;

NOW THEREFORE, this Contract is amended as follows:

CONTINUED ON 7 SHEETS, EACH BEARING NAME OF CONTRACTOR AND CONTRACT NUMBER.

The provisions on the reverse side hereof constitute a part of this agreement. IN WITNESS WHEREOF, this agreement has been executed by the parties hereto, upon the date first above written.

STATE OF CALIFORNIA	CONTRACTOR
AGENCY Department of Health Services	CONTRACTOR (if other than an individual, state whether a corporation, partnership, etc.) Molina
BY (AUTHORIZED SIGNATURE) /s/ Nadine Fujita Roh for	BY (AUTHORIZED SIGNATURE) /s/
PRINTED NAME OF PERSON SIGNING Edward Stahlberg Nadine Fujita Roh, Chief CMU PRoduction	PRINTED NAME OF AND TITLE OF PERSON SIGNING George Goldstein, President
TITLE Chief, Program Support Branch	ADDRESS One Golden Shore, Long Beach, CA 90802

AMOUNT ENCUMBERED BY THIS DOCUMENT $ -0-	PROGRAM/CATEGORY (CODE AND TITLE) Loc.Asst.Section 14157 W&I (OPTIONAL USE)			FUND TITLE Health Care Deposit	
PRIOR AMOUNT ENCUMBERED FOR THIS CONTRACT $ 527,053,310	ITEM 4260-601-912	CHAPTER 51	STATUTE 2000	FISCAL YEAR 00/01	Exempt From PCC per W&I Code Section 14087.4
TOTAL AMOUNT ENCUMBERED TO DATE $ 527,053,310	OBJECT OF EXPENDITURE (CODE AND TITLE) 9912-705-95915				
I hereby certify upon my own personal knowledge that budgeted funds are available for the period and purpose of the expenditure stated above.	T.B.A. NO.	B.R. NO.			
SIGNATURE OF ACCOUNTING OFFICER /s/		DATE 11-14-00			

[ ] CONTRACTOR [ ] STATE AGENCY [ ] DEPT. OF GEN. SER. [ ] CONTROLLER [ ]

STATE OF CALIFORNIA
STANDARD AGREEMENT
STD. 2 (REV. 5-91)(REVERSE)

1. The Contractor agrees to indemnify, defend and save harmless the State, its officers, agents and employees from any and all claims and losses accruing or resulting to any and all contractors, subcontractors, materialmen, laborers and any other person, firm or corporation furnishing or supplying work services, materials or supplies in connection with the performance of this contract, and from any and all claims and losses accruing or resulting to any person, firm or corporation who may be injured or damaged by the Contractor in the performance of this contract.

2. The Contractor, and the agents and employees of Contractor, in the performance of the agreement, shall act in an independent capacity and not as officers or employees or agents of State of California.

3. The State may terminate this agreement and be relieved of the payment of any consideration to Contractor should Contractor fail to perform the covenants herein contained at the time and in the manner herein provided. In the event of such termination, the State may proceed with the work in any manner deemed proper by the State. The cost to the State shall be deducted from any sum due the Contractor under this agreement, and the balance, if any, shall be paid the Contractor upon demand.

4. Without the written consent of the State, this agreement is not assignable by Contractor either in whole or in part.

5. Time is of the essence in this agreement.

6. No alteration or variation of the terms of this contract shall be valid unless made in writing and signed by the parties hereto, and no oral understanding or agreement not incorporated herein, shall be binding on any of the parties hereto.

7. The consideration to be paid Contractor, as provided herein, shall be in compensation for all of Contractor's expenses incurred in the performance hereof, including travel and per diem, unless otherwise expressly so provided.

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1. ARTICLE II, DEFINITIONS, SECTION Q, DMHC IS AMENDED TO READ:

Q. DMHC means the State Department of Managed Health Care, which is responsible for administering the Knox-Keene Act of 1975.

2. ARTICLE II, DEFINITIONS, SECTION PP, DMHC IS AMENDED TO READ:

PP. Knox-Keene Health Care Service Plan Act of 1975 means the law, which regulates HMOs and is administrated by the Department of Managed Health Care (DMHC), commencing with Section 1340, Health and Safety Code.

3. ARTICLE III, GENERAL TERMS AND CONDITIONS, SECTION 3.11 INSPECTION RIGHTS, IS AMENDED TO READ:

3.11 INSPECTION RIGHTS

Through the end of the records retention period specified in Section 3.32.2, Records Retention, Contractor shall allow DHS, DHHS, the Comptroller General of the United States, Department of Justice (DOJ), Bureau of Medi-Cal Fraud, Department of Managed Health Care (DMHC), and other authorized State agencies, or their duly authorized representative, including DHS' external quality review organization contractor, to inspect, monitor or otherwise evaluate the quality, appropriateness, and timeliness of services performed under this Contract, and to inspect, evaluate, and audit any and all books, records, and Facilities maintained by Contractor and subcontractors pertaining to these services at any time during normal business hours.

Books and records include, but are not limited to, all physical records originated or prepared pursuant to the performance under this Contract, including working papers, reports, financial records, and books of account, Medical Records, prescription files, laboratory results, Subcontracts, information systems and procedures, and any other documentation pertaining to medical and non-medical services rendered to Members. Upon request, through the end of the records retention period specified in Section 3.32.2, Records Retention, Contractor shall furnish any record, or copy of it, to DHS or any other entity in this section, at Contractor's sole expense.

4. ARTICLE III, GENERAL TERMS AND CONDITIONS, SECTION 3.18.3, MANDATORY TERMINATION, IS AMENDED TO READ:

3.18.3 MANDATORY TERMINATION

DHS will terminate this Contract in the event that: (1) the Secretary, DHHS, determines that the Contractor does not meet the requirements for participation in the Medicaid program, Title XIX of the Social Security Act, or (2) the Department of Managed Health Care finds that the Contractor no longer qualifies for licensure under the Knox-Keene Health Care Service Plan Act by giving written notice to the Contractor. Notification will be given by DHS at least sixty (60) days prior to the effective date of termination, except in cases where the Director determines the health and welfare of Members is jeopardized by continuation of the Contract, in which case the Contract will be immediately terminated. Notification will state the effective date of, and the reason for, the termination.

Under these circumstances, termination of the Contract will be effective on the last day of the month in which the Secretary, DHHS, or the DMHC makes such determination, provided that DHS provides the Contractor with at least 60 days notice of termination. The termination of this Contract will be effective on the last day of the second full month from the date of the notice of termination. Contractor agrees that 60 days notice is reasonable. Termination under this section does not relieve the Contractor of its obligations under the Turnover and Phaseout Requirements, Section 3.17 through 3.17.4, except that these requirements may be performed after Contract termination.

5. ARTICLE III, GENERAL TERMS AND CONDITIONS, SECTION 3.27.2, SUBCONTRACT REQUIREMENTS, IS AMENDED TO READ:

3.27.2 SUBCONTRACT REQUIREMENTS

Each Subcontract will contain:

A. The subcontractor's agreement to make all of its books and records, pertaining to the goods and services furnished under the terms of the Subcontract, available for inspection, examination or copying:

1. By DHS, DHHS, DOJ, DMHC

2. At all reasonable times at the subcontractor's place of business or at such other mutually agreeable location in California.

3. In a form maintained in accordance with the general standards applicable to such book or record keeping

4. For a term of at least five years from the close of DHS fiscal year in which the Subcontract was in effect.

5. Including all Encounter data for a period of at least five years.

B. Full disclosure of the method and amount of compensation or other consideration to be received by the subcontractor from the Contractor.

C. Subcontractor's agreement to maintain and make available to DHS, upon request, copies of all sub-subcontracts and to ensure that all sub-subcontracts are in writing and require that the sub-contractor:

1. Make all applicable books and records available at all reasonable times for inspection, examination, or copying by DHS, DHHS, DOJ and DMHC.

2. Retain such books and records for a term of at least five years from the close of DHS' fiscal year in which the sub-contract is in effect.

D. Subcontractor's agreement to assist Contractor in the transfer of care pursuant to Section 3.17.2, Turnover Requirements, in the event of Contract termination.

E. Subcontractor's agreement to notify DHS in the event the agreement with the Contractor is amended or terminated. Notice is considered given when properly addressed and deposited in the United States Postal Service as first class registered mail, postage attached.

F. Subcontractor's agreement that assignment or delegation of the Subcontract will be void unless prior written approval is obtained from DHS.

G. Subcontractor's agreement to hold harmless both the State and plan Members in the event the Contractor cannot or will not pay for services performed by the subcontractor pursuant to the Subcontract.

H. Subcontractor's agreement to provide Contractor with Encounter level data in the manner consistent with DHS requirements.

I. Subcontracts with safety-net providers will include Contractor and subcontractor's agreement to notify DHS upon termination of the subcontract.

J. Subcontractor's agreement to timely gather, preserve and provide to DHS, any records in the Subcontractor's possession, in accordance with Section 3.45, Records Related to Recovery for Tobacco Related Illnesses.

6. ARTICLE VI, SCOPE OF WORK, SECTION 6.3.3, MONTHLY FINANCIAL STATEMENT, IS AMENDED TO READ:

6.3.3 MONTHLY FINANCIAL STATEMENT

The Contractor may be required to file monthly Financial Statements at DHS' request. If the Contractor is required to file monthly Financial Statements with DMHC, they will file monthly Financial Statements with DHS.

7. ARTICLE VI, SCOPE OF WORK, SECTION 6.3.4, COMPLIANCE WITH AUDIT REQUIREMENTS, IS AMENDED TO READ:

6.3.4 COMPLIANCE WITH AUDIT REQUIREMENTS

The Contractor will cooperate with DHS' own independent audits annually or as necessary for good cause, at the discretion of DHS. Such audits may be waived upon submission of the financial audit for the same period conducted by DMHC pursuant to Section 1382 of the Health and Safety Code.

8. ARTICLE VI, SCOPE OF WORK, SECTION 6.9.5, MEMBERSHIP SERVICES GUIDE, IS AMENDED TO READ:

6.9.5 MEMBERSHIP SERVICES GUIDE

Contractor shall develop and distribute a Membership Services Guide that includes the following information:

A. The name address and telephone number of the health plan.

B. A description of the full scope of Medi-Cal covered benefits and all available services including health education, interpretive services, and "carve out" services and an explanation of any service limitations and exclusions from coverage or charges for services.

C. Procedures for obtaining Covered Services including the address and telephone number of each Service Site (locations of hospital, Primary Care Physicians, optometrists, psychologists, pharmacies, Skilled Nursing Facilities, Urgent Care Facilities). In the case of a medical foundation or independent practice association, the address and telephone number of each Physician provider.

   1. The hours and days when each of these facilities is open, the services and benefits available, and the telephone number to call after normal business hours.

D. Procedures for selecting or requesting a change in Primary Care Physician, including requirements for a change in PCP, reasons for which a request may be denied, and reasons why a provider may request a change.

E. The purpose and value of scheduling an initial health assessment appointment.

F. The appropriate use of health care services in a managed care system.

G. The availability and procedures for obtaining after hours services (24 hour basis) and care, including the appropriate provider locations and telephone numbers.

H. Procedure for obtaining emergency health care both within and outside Contractor's Service Area.

I. Process for referral to specialists.

J. Procedures for obtaining any non-medical transportation services offered by Contractor and through the local CHDP programs, and how to obtain such services.

K. The causes for which a Member shall lose entitlement re receive services under this Contract.

L. Procedures for filing a complaint/Grievance, including procedures for appealing decisions regarding Members' coverage, benefits, or relationship to the organization. Include the title, address, and telephone number of the person responsible for processing and resolving complaints/Grievances.

M. Procedures for Disenrollment, including an explanation of the Member's right to disenroll without cause at any time, subject to any restricted disenrollment period.

N. Information on the Member's right to the Medi-Cal fair hearing process regardless of whether or not a complaint/Grievance has been submitted or if the complaint/Grievance has been resolved, pursuant to Title 22, CCR, Section 53452, when a health care service requested by the Member or provider has been denied, deferred or modified. The State Department of Social Services' Public Inquiry and Response Unit toll free telephone number (800) 952-5253.

O. Information on the availability of, and procedures for obtaining, services at FQHCs and Indian Health Clinics.

P. Information on the Member's right to seek family planning services from any qualified provider of family planning services, under the Medi-Cal program, including providers outside Contractor's provider network, and a description of those services, such as the following statement:

"Family planning services are provided to Members of child bearing age to enable them to determine the number and spacing of children. These services include all methods of birth control approved by the Federal Food and Drug Administration. As a Member, you pick a doctor who is located near you and will give you the services you need. Our Primary Care Physicians and OB/GYN specialists are available for family planning services. For family planning services, you may also pick a doctor or clinic not connected with Molina without having to get permission from Molina. Molina shall pay that doctor or clinic for the family planning services you get."

Q. The DHS' Office of Family Planning's toll free telephone number (1-800-942-1054) providing consultation and referral to family planning clinics.

R. Any other information determined by the DHS to be essential for the proper receipt of Covered Services.

S. Information on the availability of, and procedures for obtaining, Certified Nurse Midwife and Certified Nurse Practitioner services, pursuant to Section 6.7.4.14, Nurse Midwife and Nurse Practitioner Services.

T. Information on the availability of transitional Medi-Cal eligibility and how the Member may apply for this program. Contractor shall include this information with all membership Services Guides sent to Members after the date such information is furnished to Contractor by DHS.

U. Information on how to access State resources for investigation and resolution of Member complaints, including the DHS Medi-Cal Managed Care Ombudsman and toll-free telephone number (1-888-452-8609) and the DMHC HMO Consumer Service toll-free telephone Number (1-800-400-0815).

V. Information concerning the provision and availability of services covered under the CCS program from providers outside Contractor's provider network and how to access these services.

W. An explanation of the expedited disenrollment process for children receiving services under the Foster Care or Adoption Assistance Programs; Members with special health care needs, including, but not limited to major organ transplants; and Members already enrolled in another Medi-Cal, Medicare or commercial managed care plan.

X. Information how to obtain Minor Consent Services through Contractor's plan, and an explanation of those services.

Y. A brief explanation on how to use the fee-for-service system when Medi-Cal covered services are excluded or limited under this Contract and how to obtain additional information.

Z. An explanation of an American Indian Member's right to access Indian Health Service Facilities and to disenroll from Contractor's plan at any time, without cause.

AA. Subsections S through Z above, except subsections T, shall be included in Contractor's Membership Services Guide by April 1, 1999, or upon the next reprinting of Contractor's Membership Services Guide, whichever is sooner.

9. The effective date of this Amendment is September 1, 2000.

10. All rights duties, liabilities, and obligations of the parties hereto otherwise remain unchanged.

STATE OF CALIFORNIA

STANDARD AGREEMENT -- APPROVED BY THE ATTORNEY GENERAL
STD. 2(REV.5-91)

CONTRACT NUMBER: 95-23637
AM. NO.: 6
TAXPAYER'S FEDERAL ID NUMBER: 33-0342719

THIS AGREEMENT, made and entered into this 1st day of July, 2001 in the State of California, by and between State of California, through its duly elected or appointed, qualified and acting

TITLE OF OFFICER ACTING FOR STATE
Chief, Program Support Branch

AGENCY
Department of Health Services, hereafter called the State, and

CONTRACTOR'S NAME
Molina Healthcare of California dba: Molina, hereafter called the Contractor:

WITNESSETH: That the Contractor for and in consideration of the covenants, conditions, agreements, and stipulations of the State hereinafter expressed does hereby agree to furnish to the State services and materials as follows: (Set forth services to be rendered by Contractor, amount to be paid contractor. time for performance or completion, and attach plans and specifications, if any.)

AMENDMENT A-6 TO CONTRACT NO.95-23637 BETWEEN MOLINA HEALTHCARE OF CALIFORNIA, dba: MOLINA AND THE STATE OF CALIFORNIA; AND

WHEREAS, the State of California and Molina Healthcare of California, dba: Molina entered into a Contract to provide health care services to Medi-Cal beneficiaries dated April 2, 1996, and;

NOW THEREFORE, this Contract is amended as follows:

CONTINUED ON 5 SHEETS, EACH BEARING NAME OF CONTRACTOR AND CONTRACT NUMBER.

The provisions on the reverse side hereof constitute a part of this agreement. IN WITNESS WHEREOF, this agreement has been executed by the parties hereto, upon the date first above written.

STATE OF CALIFORNIA	CONTRACTOR
AGENCY Department of Health Services	CONTRACTOR (If other than an individual, state whether a corporation, partnership, etc.) Molina Healthcare of California, dba: Molina
BY (AUTHORIZED SIGNATURE) /s/ for	BY (AUTHORIZED SIGNATURE) /s/
PRINTED NAME OF PERSON SIGNING Edward Stahlberg Nadine Fujita Roh, Chief CMU Production	PRINTED NAME OF AND TITLE OF PERSON SIGNING J. Mario Molina, CEO
TITLE Chief, Program Support Branch	ADDRESS One Golden Shore Drive, Long Beach, CA 90802

AMOUNT ENCUMBERED BY THIS DOCUMENT $ -0-	PROGRAM/CATEGORY (CODE AND TITLE) Loc.Asst.Section 14157 W&I	FUND TITLE Health Care Deposit
PRIOR AMOUNT ENCUMBERED FOR THIS CONTRACT $ 527,053,310	(OPTIONAL USE) ITEM 4260-601-912; CHAPTER 52; STATUTE 2000; FISCAL YEAR 00/01	Exempt From PCC per W&I Code Section 14087.4
TOTAL AMOUNT ENCUMBERED TO DATE $ 527,053,310	OBJECT OF EXPENDITURE (CODE AND TITLE) 9912-705-95915	
I hereby certify upon my own personal knowledge that budgeted funds are available for the period and purpose of the expenditure stated above.	T.B.A. NO.	B.R. NO.
SIGNATURE OF ACCOUNTING OFFICER /s/	DATE 5/24/01	

[ ] CONTRACTOR [ ] STATE AGENCY [ ] DEPT. OF GEN. SER. [ ] CONTROLLER [ ]

STATE OF CALIFORNIA
STANDARD AGREEMENT
STD. 2 (REV. 5-91) (REVERSE)

1. The contractor agrees to indemnify, defend and save harmless the State, its officers, agents and employees from any and all claims and losses accruing or resulting to any and all contractors, subcontractors, materialmen, laborers and any other person, firm or corporation furnishing or supplying work services, materials or supplies in connection with the performance of this contract, and from any and all claims and losses accruing or resulting to any person, firm or corporation who may be injured or damaged by the Contractor in the performance of this contract.

2. The Contractor, and the agents and employees of Contractor, in the performance of the agreement, shall act in an independent capacity and not as officers or employees or agents of State of California.

3. The State may terminate this agreement and be relieved of the payment of any consideration to Contractor should Contractor fail to perform the covenants herein contained at the time and in the manner herein provided. In the event of such termination the State may proceed with the work in any manner deemed proper by the State. The cost to the state shall be deducted from any sum due the Contractor under this agreement, and the balance, if any, shall be paid the Contractor upon demand.

4. Without the written consent of the State, this agreement is not assignable by Contractor either in whole or in part.

5. Time is of the essence in this agreement.

6. No alteration or variation of the terms of this contract shall be valid unless made in writing and signed by the parties hereto, and no oral understanding or agreement not incorporated herein, shall be binding on any of the parties hereto.

7. The consideration to be paid Contractor, as provided herein, shall be in compensation for all of Contractor's expenses incurred in the performance hereof, including travel and per diem, unless otherwise expressly so provided.

1. ARTICLE II - DEFINITIONS, SECTION Y, ELIGIBLE BENEFICIARY IS AMENDED TO READ:

"Y. Eligible Beneficiary means any Medi-Cal beneficiary who is residing in Contractor's Service Area with one of the following aid codes: Family: 01,OA, 02, 08, 30, 32, 33, 34, 35, 38, 39, 40, 42, 47, 54, 59, 72, 3A, 3C, 3E, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 4F, 4G, 5X, 7X, 8P; Aged: 1H, 10, 14, 16, 18; Disabled: 20, 24, 26, 28, 36, 60, 64, 66, 68, 6A, 6C, 6H, 6N, 6P, 6R; Child: 03, 04, 4A, 4C, 4K, 5K, 45, 7A, 7J, 8R, 82; Adult: 86; with the following exclusions:

1. Individuals who have been approved by the Medi-Cal Field Office or the California Children Services Program for bone marrow, heart, heart-lung, liver, lung, combined liver, and kidney, or combined liver and small bowel transplants.

2. Individuals who elect and are accepted to participate in the following Medi-Cal waiver programs: In-Home Medical Care Waiver Program, the Skilled Nursing Facility Waiver Program, the Model Waiver Program, the Acquired Immune Deficiency (AIDS) and AIDS Related Conditions Waiver Program, and the Multipurpose Senior Services Waiver Program.

3. Individuals determined by the Medi-Cal Field Office to be in need of long term care and residing in a Skilled Nursing Facility (SNF) for 30 days past the month of admission.

4. Individuals who have commercial or Medicare HMO coverage, unless the Medicare HMO is a provider under this Contract and DHS has agreed, as a term of the HMO's Contract, that these individuals may be enrolled, and DHS and the Medicare HMO have negotiated an appropriate rate for these individuals. Individuals with Medicare fee-for-service coverage are not excluded from enrolling under this Contract."

2. ARTICLE III ~ GENERAL TERMS AND CONDITIONS, SECTION 3.49, PROHIBITED USE OF STATE FUNDS FOR UNION ORGANIZING IS BEING ADDED TO YOUR CONTRACT TO READ:

"3.49 Prohibited Use of State Funds for Union Organizing

Contractor by signing this agreement hereby acknowledges the applicability of Government Code Section 16645 through Section 16649 to this agreement.

1. Contractor will not assist, promote, or deter union organizing by employees performing work on a state service contract, including a public works contract.

2. No state funds received under this agreement will be used to assist, promote, or deter union organizing.

3. Contractor will not, for any business conducted under this agreement, use any state property to hold meetings with employees or supervisors, if the purpose of such meetings is to assist, promote or deter union organizing, unless the state property is equally available to the general public for holding meetings.

4. If Contractor incurs costs, or makes expenditures to assist, promote or deter union organizing, Contractor will maintain records sufficient to show that no reimbursement from state funds has been sought for these costs, and that Contractor shall provide those records to the Attorney General upon request."

3. ARTICLE III -- GENERAL TERMS AND CONDITIONS, SECTION 3.50, DEBARMENT AND SUSPENSION CERTIFICATION, IS BEING ADDED TO YOUR CONTRACT TO READ:

"3.50 Debarment and Suspension Certifications

By signing this agreement, the Contractor/Grantee agrees to comply with the applicable federal suspension and debarment regulations, and certifies the following:

A. The Contractor/Grantee certifies to the best of its knowledge and belief, that it and its principals:

1. Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in a federally sponsored project by any federal department or agency;

2. Have not within a three-year period preceding this agreement been convicted of or had a civil judgement rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

3. Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State or Local) with commission of any of the offenses enumerated in the foregoing paragraph of this certification; and

4. Have not within a three-year period preceding this agreement had one or more public transactions (Federal, State or local) terminated for cause or default.

5. Contractor/Grantee shall not knowingly enter into any lower tier covered transaction with a person or firm that is proposed for debarment under federal regulations, debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transactions, unless authorized by the State. The Contractor/Grantee may rely on the certification of a prospective participant in a lower tier covered transaction unless it knows that the certification is erroneous. The Contractor/Grantee may, but is not required to, check the Procurement and Nonprocurement List issued by U.S. General Service Administration at the following Internet site: http://epls.arnet.gov/.

6. Contractor/Grantee will include a clause entitled, "Debarment and Suspension Certification" that essentially sets forth the provisions herein, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

B. If the Contractor/Grantee is unable to certify to any of the statements in this certification, the Contractor/Grantee shall submit an explanation to the DHS program funding this agreement.

C. The terms and definitions herein have the meanings set out in the Definitions and Coverage sections of the rules implementing Federal Executive Order 12549.

D. If the Contractor/Grantee knowingly violates this certification, in addition to other remedies available to the Federal Government, DHS may terminate this agreement for cause or default."

4. ARTICLE V - PAYMENT PROVISIONS, SECTION 5.3, CAPITATION RATES, IS AMENDED TO READ:

"5.3 Capitation Rates

DHS shall remit to Contractor a capitation payment each month for each Medi-Cal Member that appears on the approved list of Members supplied to Contractor by DHS. The capitation rate shall be the amount specified in this Article. The payment period for health care services shall commence on the first day of operations, as determined by DHS. Capitation payments shall be made in accordance with the following schedule of capitation payment rates:

FOR THE PERIOD OF 10/01/00 - 9/30/01 RIVERSIDE

GROUPS	AID CODES	RATES
Family	01, 0A, 02, 08, 30, 32, 33, 34, 35, 38, 39, 40, 42, 47, 54, 59, 72, 3A, 3C, 3E, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 4F, 4G, 5X, 7X, 8P	$ 86.14
Disabled	20, 24, 26, 28, 36, 60, 64, 66, 68, 6A, 6C, 6H, 6N, 6P, 6R	$223.64
Aged	1H, 10, 14, 16, 18	$160.60
Child	03, 04, 4A, 4C, 4K, 5K, 45, 7A, 7J, 8R, 82	$ 89.04
Adult	86	$843.25
Aids Beneficiary		$847.95

FOR THE PERIOD OF 10/01/00 - 9/30/01 SAN BERNARDINO

GROUPS	AID CODES	RATES
Family	01, 0A, 02, 08, 30, 32, 33, 34, 35, 38, 39, 40, 42, 47, 54, 59, 72, 3A, 3C, 3E, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 4F, 4G, 5X, 7X, 8P	$ 82.56
Disabled	20, 24, 26, 28, 36, 60, 64, 66, 68, 6A, 6C, 6H, 6N, 6P, 6R	$223.41
Aged	1H, 10, 14, 16, 18	$151.60
Child	03, 04, 4A, 4C, 4K, 5K, 45, 7A, 7J, 8R, 82	$ 93.48
Adult	86	$922.71
Aids Beneficiary		$891.15

If DHS creates a new aid code that is split or derived from an existing aid code covered under this Contract, and the aid code has a neutral revenue effect for the Contractor, then the split aid code will automatically be included in the same aid code category as is the original aid code covered under this Contract. Contractor agrees to continue providing covered services to the Members at the monthly capitation rate specified for the original aid code. DHS shall confirm all aid code splits, and the rates of payment for such new aid codes, in writing to Contractor as soon as practicable after such aid code splits occur.

5. The effective date of this Amendment is July 1, 2001.

6. The effective date of 1H and 6H is May 1, 2001

7. All rights duties, liabilities, and obligations of the parties hereto otherwise remain unchanged.

Enclosure I

The purpose of this enclosure to Molina Healthcare of California, dba Molina, amendment 6, Contract Number 95-23637 is to provide you the Contractor with an explanation for the amendment.

This amendment adds an Aid Code 7J to your existing contract, which is result of recent legislation that allows certain categories of Children under the age of 19, to have their eligibility continued for one more year. This aid code was added to the child category with no increase in rate.

This amendment adds Aid Code 1H to the Aged category and 6H to the Disabled category.

This amendment also adds two (2) new Sections to your existing Contract.

The first is Section 3.47, Prohibition of the use of State funds for Union Organizing. This section is mandated by Legislative Bill AB1839 and must be included in all contracts, which are initiated by the State. This section prohibits the use of state funds to assist, promote, or deter union organizing by employees performing work on a state contract or use state property to hold meetings if the purpose of the meeting is to assist, promote or deter union organizing.

The second is Section 3.48, Debarment and Suspension. This section requires language of a certification by contractor that contractor principals are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in a federally qualified project by any federal department or agency. Have not within the last three years been convicted or had civil judgement rendered against them. This section is required by federal law and must be included in any state contract receiving federal funding of $50,000 dollars or more.

STATE OF CALIFORNIA

APPROVED BY THE ATTORNEY GENERAL

STANDARD AGREEMENT --
STD. 2 (REV. 5-91)

CONTRACT NUMBER	AM. NO.
95-23637	7

TAXPAYER'S FEDERAL ID. NUMBER
33-0342719

THIS AGREEMENT, made and entered into this 1st day of June, 2001 in the State of California, by and between State of California, through its duly elected or appointed, qualified and acting

TITLE OF OFFICER ACTING FOR STATE	AGENCY
Chief, Program Support Branch	Department of Health Services, hereafter called the State, and

CONTRACTOR'S NAME

Molina Healthcare of California dba Molina, hereafter called the Contractor.

WITNESSETH: That the Contractor for and in consideration of the covenants, conditions, agreements, and stipulations of the State hereinafter expressed, does hereby agree to furnish to the State services and materials as follows: (Set forth services to be rendered by Contractor, amount to be paid Contractor, time for performance or completion, and attach plans and specifications, if any.)

Amendment A07 to Contract No. 95-23637 BETWEEN MOLINA HEALTHCARE OF CALIFORNIA dba MOLINA AND THE STATE OF CALIFORNIA;

WHEREAS, the State of California and Molina Healthcare of California dba Molina entered into this Contract to provide healthcare services to Medi-Cal beneficiaries, under the provisions of Welfare and Institution Code Section 14087.4, dated Ap 1, 1996, and subsquently amended;

NOW THEREFORE, this Contract is amended as follows:

CONTINUED ON 1 SHEETS, EACH BEARING NAME OF CONTRACTOR AND CONTRACT NUMBER.

The provisions on the reverse side hereof constitute a part of this agreement.
IN WITNESS WHEREOF, this agreement has been executed by the parties hereto, upon the date first above written.

STATE OF CALIFORNIA	CONTRACTOR
AGENCY Department of Health Services	CONTRACTOR (if other than an individual, state whether a corporation, partnership. etc.) Molina Healthcare of California dba Molina
BY Nadine Fujita Roh For	BY
PRINTED NAME OF PERSON SIGNING Edward Stahlberg Nadine Fujita Roh. Chief CMU Production	PRINTED NAME OF AND TITLE OF PERSON SIGNING George S. Goldstein, Ph.D
TITLE Chief, Program Support Branch	ADDRESS One Golden Shore Drive, Long Beach, CA 90802

AMOUNT ENCUMBERED BY THIS DOCUMENT	PROGRAM/CATEGORY (CODE AND TITLE)	FUND TITLE	Department of General Services Use Only
$ 27,000,000	Loc.Asst.Section 14157 W&I Code	Health CareDeposit	
	(OPTIONAL USE)		

PRIOR AMOUNT ENCUMBERED FOR THIS CONTRACT
$ 607,053,310

ITEM	CHAPTER	STATUTE	FISCAL YEAR
4260-601-912	106	2001	2001/2002

Exempt per W&I Code 14087.4

TOTAL AMOUNT ENCUMBERED FOR DATE
$ 634,053,310

OBJECT OF EXPENDITURE (CODE AND TITLE)
9912-705-95915

I hereby certify upon my own personal knowledge that budgeted funds are available for the period and purpose of the expenditure stated above. T.B.A. NO. B.R.NO.

SIGNATURE OF ACCOUNTING OFFICER

DATE
11/7/01

[ ] CONTRACTOR [ ] STATE AGENCY [ ]DEPT. OF GEN.SER. [ ] CONTROLLER [ ]

STATE OF CALFORNIA
STANDARD AGREEMENT
STD. 2 (REV. 5-91) (REVERSE)

1. The contractor agrees to indemnify, defend and save harmless the State, its officers, agents and employees from any and all claims and losses accruing or resulting to any and all contractors, subcontractors materialmen, laborers and any other person, firm or corporation furnishing or supplying work services materials or supplies in connection with the performance of this contract, and from any and all claims and losses accruing or resulting to any person, firm or corporation who may be injured or damaged by the Contractor in the performance of this contract.

2. The Contractor, and the agents and employees of Contractor, in the performance of the agreement, shall act in an independent capacity and not as officers or employees or agents of State of California.

3. The State may terminate this agreement and be relieved of the payment of any consideration to Contractor, should Contractor fail to perform the covenants herein contained at the time and in the manner herein provided. In the event of such termination, the State may proceed with the work in any manner deemed proper by the State. The cost to the state shall be deducted from any sum due the Contractor under this agreement, and the balance, if any, shall be paid the Contractor upon demand.

4. Without the written consent of the State, this agreement is not assignable by Contractor either in whole or in part.

5. Time is the essence of this agreement.

6. No alteration or variation of the terms of this contract shall be valid unless made in writing and signed the parties hereto, and no oral understanding or agreement not incorporated herein, shall be binding on any of the parties hereto.

7. The consideration to be paid Contractor, as provided herein, shall be in compensation for all of Contractor's expenses incurred in the performance hereof, including travel and per diem, unless otherwise expressly so provided.

1. ARTICLE III, GENERAL TERMS AND CONDITIONS, Section 3.14, Term, paragraph 1 is amended to read:

   3.14 TERM

   This Contract will become effective April 2, 1996 and will continue in full force and effect through March 31, 2003, subject to the provisions of Article V, Sections 5.2 and 5.10 because the State has currently appropriated and available for encumbrance only funds to cover costs through June 30, 2001.

   All other provisions of this Section remain unchanged.

2. ARTICLE V, PAYMENT PROVISIONS, Section 5.2, Amounts Payable, is amended to read:

   5.2 AMOUNTS PAYABLE

   The maximum amount payable for the 1995-96 Fiscal Year ending June 30, 1996 will not exceed $32,080,630; the maximum amount payable for the Fiscal Year 1996-97 Fiscal Year ending June 30, 1997 will not exceed $194,472,680; the maximum amount payable for the 1997-98 Fiscal Year ending June 30,1998 will not exceed $6,500,000; the maximum amount payable for the 1998-99 Fiscal Year ending June 30,1999 will not exceed $80,000,000; the maximum amount payable for the 1999-2000 Fiscal Year ending June 30, 2000 will not exceed $107,000,000; the maximum amount payable for the 2000-2001 Fiscal Year ending June 30, 2001 will not exceed $107,000,000. Any requirement for performance by DHS and Contractor for the period of the Contract subsequent to June 30, 2001, will be dependent upon the availability of future appropriations by the Legislature for the purpose of this Contract. If funds become available for purposes of this Contract from future appropriations by the Legislature, the maximum amount payable for the 2001-2002 Fiscal Year ending June 30, 2002 will not exceed $107,000,000; the maximum amount payable for the 2002-2003 Fiscal Year ending June 30, 2003 will not exceed $80,000,000. The maximum amount payable for this Contract will not exceed $714,053,310.

3. The effective date of this Amendment is June 1, 2001.

4. All rights, duties, liabilities and obligations of the parties hereto otherwise remain unchanged.

Enclosure 1

The purpose of this enclosure to Molina's amendment 07 to Contract Number 96-23637 is to provide you the Contractor with an explanation for the amendment.

This amendment extends the term of your contract to March 31, 2003.

This amendment also changes the amounts payable under your contract to add additional dollars into the 2001-2002 Fiscal Year, and for the additional 2002- 2003 Fiscal Year, to allow payment for that fiscal year, as a result of the increase in the term of the contract.

STATE Of CALIFORNIA
STANDARD AGREEMENT AMENDMENT
STD. 213 A (NEW 02/98)

AGREEMENT NUMBER	AMENDMENT NUMBER
95-23637	8

This Agreement is entered into between the State Agency and Contractor named below:

STATE AGENCY'S NAME
California Department of Health Services

CONTRACTOR'S NAME
Molina Healthcare of California, dba: Molina

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2. The term of this Agreement is 4-2-96 through 3-31-02

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3. The maximum amount of this Agreement is: $714,053,310
Seven hundred and fourteen million, fifth-three thousand, three hundred ten

---

4. The parties mutually agree to this amendment as follows. All actions noted below are by this reference made a part of the Agreement and incorporated herein:

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5. Article II - Definitions, Section Y, Eligible Beneficiary, is amended to add two new Aid Codes: 4M to category Family and 6V to category Disabled, to read as in page 2 of this amendment.

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6. Article V - Payment Provision, Section 5.3, Capitation Rates, is amended to add two new Aid Codes: 4M to category Family and 6V to category Disabled, to read as in page 3 of this amendment.

All other terms and conditions shall remain the same.

IN WITNESS WHEREOF, this Agreement has been executed by the parties hereto.

CONTRACTOR	CALIFORNIA Department of General Services Use Only
CONTRACTOR'S NAME (If other than an individual, state whether a corporation, partnership, etc.) Molina Healthcare of California, dba: Molina	
BY (Authorized Signature) DATE SIGNED (Do not type) /s/	
PRINTED NAME AND TITLE OF PERSON SIGNING George S. Goldstein	
ADDRESS One Golden Shore Drive, Long Beach, CA 90802	
STATE OF CALIFORNIA	
AGENCY NAME California Department of Health Services	
BY (Authorized Signature) for DATE SIGNED (Do not type) /s/ Nadine Fujita Roh for 04/05/02	
PRINTED NAME AND TITLE OF PERSON SIGNING Edward Stahlberg, Chief, Program Support Branch	
ADDRESS 1800 3rd. Street, Rm. 455, P.O. Box 942732, Sacramento, CA 94234-7320	X Exempt per: 14087.4

STATE OF CALIFORNIA
STANDARD AGREEMENT
STD. 2 (REV. 5-91) (REVERSE)

1. The Contractor agrees to indemnify, defend and save harmless the State, its officers, agents and emp1oyees from any and all claims and losses accruing or resulting to any and all contractors, subcontractors, materialmen, laborers and any other person, firm or corporation furnishing or supplying work services materials or supplies in connection with the performance of this contract, and from any and all claims losses accruing or resulting to any person, firm or corporation who may be injured or damaged by Contractor in the performance of this contract.

2. The Contractor, and the agents and employees of Contractor, in the performance of the agreement, shall act in an independent capacity and not as officers or employees or agents of State of California.

3. The State may terminate this agreement and be relieved of the payment of any consideration to Contractor should Contractor fail to perform the covenants herein contained at the time and in the manner herein provided. In the event of such termination the State may proceed with the work in any manner deemed proper by the State. The cost to the State shall be deducted from any sum due the Contractor under this agreement, and the balance, if any, shall be paid the Contractor upon demand.

4. Without the written consent of the State, this agreement is not assignable by Contractor either in whole or in part.

5. Time is of the essence in this agreement.

6. No alteration or variation of the terms of this contract shall be valid unless made in writing and signed by the parties hereto, and no oral understanding or agreement not incorporated herein, shall be binding on any of the parties hereto.

7. The consideration to be paid Contractor, as provided herein, shall be in compensation for all of Contractor's expenses incurred in the performance hereof, including travel and per diem, unless otherwise expressly so provided.

1. Article II - Definitions, Section Y, Eligible Beneficiary, is amended to read:

"Y. Eligible Beneficiary means any Medical beneficiary who is residing in Contractor's Service Area with one of the following aid codes: Family - aid codes 01, 0A, 02, 08, 30, 32, 33, 34, 35, 38, 39, 40, 42, 47, 54, 59, 72, 3A, 3C, 3E, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 4F, 4G, 4M, 5X, 7X, 8P; Aged - aid codes 10, 14, 16, 18, 1H; Disabled - aid codes 20, 24, 26, 28, 36, 60, 64, 66, 68, 6A, 6C, 6H, 6N, 6P, 6R, 6V; Child - aid codes 03, 04, 45, 82, 4A, 4C, 4K, 5K, 7A, 7J, 8R; Adult- aid code 86 with the following exclusions:

1. Individuals who have been approved by the Medi-Cal Field Office or the California Children Services Program for bone marrow, heart, heart-lung, liver, lung, combined liver, and kidney, or combined liver and small bowel transplants.

2. Individuals who elect and are accepted to participate in the following Medi-Cal waiver programs: In-Home Medical Care Waiver Program, the Skilled Nursing Facility Waiver Program, the Model Waiver Program, the Acquired Immune Deficiency (AIDS) and AIDS Related Conditions Waiver Program, and the Multipurpose Senior Services Waiver Program.

3. Individuals determined by the Medi-Cal Field Office to be in need of long term care and residing in a Skilled Nursing Facility (SNF) for 30 days past the month of admission.

4. Individuals who have commercial or Medicare HMO coverage, unless the Medicare HMO is a provider under this Contract and DHS has agreed, as a term of the HMO's Contract, that these individuals may be enrolled, and DHS and the Medicare HMO have negotiated an appropriate rate for these individuals. Individuals with Medicare fee-for-service coverage are not excluded from enrolling under this Contract."

2. Article V - Payment Provision, Section 5.3, Capitation Rates, is amended to read:

"5.3 Capitation Rates

DHS shall remit to Contractor a capitation payment each month for each Medi-Cal Member that appears on the approved list of Members supplied to Contractor by DHS. The capitation rate shall be the amount specified in this Article. The payment period for health care services shall commence on the first day of operations, as determined by DHS. Capitation payments shall be made in accordance with the following schedule of capitation payment rates:

For the period 10/01/00 - 9/30/01 Riverside

Groups	Aid Codes	Rate
Family	01, 0A, 02, 08, 30, 32, 33, 34, 35, 38, 39, 40, 42, 47, 54, 59, 72, 3A, 3C, 3E, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 4F, 4G, 4M, 5X, 7X, 8P	$ 86.14
Disabled	20, 24, 26, 28, 36, 60, 64, 66, 68, 6A, 6C, 6N, 6P, 6R, 6V, 6H	$ 223.64
Aged	10,14,16,18, 1H	$ 160.60
Child	03, 04, 4A, 4C, 4K, 5K, 45, 82, 7A, 7J, 8R	$ 89.04
Adult	86	$ 843.25
Aids Beneficiary		$ 847.95

MOLINA HEALTHCARE OF CALIFORNIA,
DBA: MOLINA
95-23637 A-08

For the period 10/01/00 - 9/30/01 San Bernardino

Groups	Aid Codes	Rate
Family	01, OA, 02, 08, 30, 32, 33, 34, 35, 38, 39, 40, 42, 47, 54, 59, 72, 3A, 3C, 3E, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 4F, 4G, 4M, 5X, 7X, 8P	$ 82.56
Disabled	20, 24, 26, 28, 36, 60, 64, 66, 68, 6A, 6C, 6N, 6P, 6R, 6V, 6H	$ 223.41
Aged	10, 14, 16, 18, 1H	$ 151.60
Child	03, 04, 4A, 4C, 4K, 5K, 45, 82, 7A, 7J, 8R	$ 93.48
Adult	86	$ 922.71
Aids Beneficiary		$ 891.15

If DHS creates a new aid code that is split or derived from an existing aid code covered under this Contract, and the aid code has a neutral revenue effect for the Contractor, then the split aid code will automatically be included in the same aid code category as is the original aid code covered under this Contract. Contractor agrees to continue providing covered service to the Members at the monthly capitation rate specified for the original aid code. DHS shall confirm all aid code splits, and the rates of payment for such new aid codes, in writing to Contractor as soon as practicable after such aid code splits occur."

3. The effective date of this amendment is September 1, 2001.

STATE OF CALIFORNIA
STANDARD AGREEMENT AMENDMENT
TO [ILLEGIBLE] A (REV [ILLEGIBLE])

[X] CHECK HERE IF ADDITIONAL PAGES ARE ATTACHED 1 Pages - AGREEMENT NUMBER 95-23637 AMENDMENT NUMBER 9

1. This Agreement is entered into between the State Agency and Contractor named below:

STATE AGENCY'S NAME

California Department of Health Services

CONTRACTOR'S NAME

Molina Healthcare of California, dba: Molina

2. The term of this Agreement is 4-2-96 through 3-31-04

3. The maximum amount of this Agreement is: $794,653,310 Seven hundred ninety-four million, six hundred fifty-three thousand, three hundred ten

4. The parties mutually agree to this amendment as follows. All actions noted below are by this reference made a part of the Agreement and incorporated herein:

I. The effective date of this Amendment is September 1, 2002.

II. The purpose of this amendment is to extend the term of the contract for one-year, adjust the encumbrance accordingly, add language, and update the list of drugs carved-out.

III. Article III - GENERAL TERMS AND CONDITIONS, Section 3.14, Term is amended to extend the term.

IV. Article V - PAYMENT PROVISIONS, Section 5.2 Amounts Payable, is amended to adjust the encumbrance.

V. Article VI - SCOPE OF WORK, Section 6.6.23, Subcontractor Services to Non-Plan Medi-Cal Beneficiaries, is amended to address subcontractors are not prohibited from Knox-Keene licensed health services plans.

VI. Attachments II and III, Excluded Drugs, is amended to add Psychotherapeutic and HIV & AIDS drugs.

All other terms and conditions shall remain the same.

IN WITNESS WHEREOF, this Agreement has been executed by the parties hereto.

CONTRACTOR

CONTRACTOR'S NAME (if other than an individual, state whether a corporation, partnership, etc.)

Molina Healthcare of California, dba: Molina

BY (Authorized Signature) DATE SIGNED (Do not type)

/s/ 8/2/02

PRINTED NAME AND TITLE OF PERSON SIGNING
George Goldstein, President/CEO

ADDRESS
One Golden Shore Dr., Long Beach, CA 90802

STATE OF CALIFORNIA

AGENCY NAME
California Department of Health Services

BY (Authorized Signature) DATE SIGNED (Do not type)
/s/ NADINE FUJITA ROH for 09/06/02

PRINTED NAME AND TITLE OF PERSON SIGNING
Edward Stahlberg, Chief, Program Support Branch

Nadine Fujita Roh, Chief
CMU Production

ADDRESS
[ILLEGIBLE] 3rd. Street, Rm. 455, P.O. Box 942732, Sacramento, CA 94234-7320

CONTRACTOR
Department of General Services
Use Only

X Exempt per W&I Code 14087.4

1. Article III - GENERAL TERMS AND CONDITIONS, Section 3.14, Term, is amended to read:

"3.14 Term

This Contract will become effective October 1, 1996, and will continue in full force and effect through March 31, 2004, subject to the provision of Article V, Section 5.2 and 5.10, because the State has currently appropriated and available for encumbrance only funs to cover cost through June 30, 2002."

2. Article V - PAYMENT PROVISIONS, Section 5.2 Amounts Payable, is amended to read:

"5.2 Amounts Payable

The maximum amount payable for the 1995-96 Fiscal Year ending June 30, 1996, will not exceed $32,080,630; the maximum amount payable for the 1996-97 Fiscal Year ending June 30, 1997, will not exceed $194,472,680; the maximum amount payable for the 1997-98 Fiscal Year ending June 30, 1998, will not exceed $6,500,000; the maximum amount payable for the 1998-99 Fiscal Year ending June 30, 1999, will not exceed $80,000,000; the maximum amount payable for the 1999-00 Fiscal Year ending June 30, 2000, will not exceed $107,000,000; the maximum amount payable for the 2000-01 Fiscal Year ending June 30, 2001, will not exceed $107,000,000; the maximum amount payable for the 2001-02 Fiscal Year ending June 30, 2002, will not exceed $107,000,000. Any requirement for performance by DHS and Contractor for the period of the Contract subsequent to June 30, 2002 will be dependent upon the purposes of this Contract. If funds become available for purposes of this Contract for future appropriations by the Legislature, the maximum amount payable for the 2002-03 Fiscal Year ending June 30, 2003, will not exceed $90,200,000; the maximum amount payable for the 2003-04 Fiscal Year ending June 30, 2004, will not exceed $70,400,000. The maximum amount payable for this Contract will not exceed $794,653,310."

3. Article VI - SCOPE OF WORK, Section 6.6.23, Subcontractor Services to Non-Plan Medi-Cal Beneficiaries, is amended to read:

"6.6.23 Subcontractor Services to Non-Plan Medi-Cal Beneficiaries

The Contractor will not prohibit any subcontractor from providing services to Medi-Cal beneficiaries who are not Members of Contractor's plan. Exclusivity requirements are not prohibited for subcontracting Knox-Keene Licensed health services plans."

Under Article II, DEFINITIONS, Section P, Covered Services, Subparagraph 19, Attachment II, is amended to read:

ATTACHMENT II

EXCLUDED DRUGS FOR THE TREATMENT OF HIV AND AIDS

Generic Name
Abacavir Sulfate
Abacavir Sulfate/Lamivudine/Zidovudine
Amprenavir
Indinavir Sulfate
Efavirenz
Lamivudine
Saquinavir
Lopinavir/Ritonavir
Ritonavir
Delavirdine Mesyiate
Saquinavir Mesyiate
Tenofovir Disoproxil Fumarate
Nelfinavir Mesyiate
Nevirapine
Stavudine
Zidovudine/Lamivudine

Under Article VI, SCOPE OF WORK, Section 6.7.3.3, Mental Health, Attachment III, is amended to read:

ATTACHMENT III

EXCLUDED PSYCHOTHERAPEUTIC DRUGS

Generic Name
- ------------

Amantadine HCL
Benztropine Mesylate
Biperiden HCL
Biperiden Lactate
Chlorpromazine HCL
Chlorprothixene
Clozapine
Fluphanazine Decanoate
Fluphanazine Enanthate
Fluphanazine HCL
Haloperidol
Haloperidol Deconoate
Haloperiodol Lactate
Isocarboxazid
Lithium Carbonate
Lithium Citrate
Lozapine HCL
Loxapine Succinate
Mesoridazine Besylate
Molindone HCL
Olanzapine
Perphenazine
Phenelzine Sulfate
Pimozide
Procyclidine HCL
Promazine HCL
Quetiapine
Risperidone
Thioridazine HCL
Thiothixene
Thiothixene HCL
Tranylcypromine Sulfate
Trifluoperazine HCL
Triflupromazine HCL
Trihexphenidyl HCL
Ziprasidone

[LETTERHEAD OF DEPARTMENT OF HEALTH SERVICES]

May 7, 1999 [SEAL]

John Molina, M.D.
Molina Medical Centers, Inc.
One Golden Shore
Long Beach, CA 90802

Dear Mr. Molina:

In accordance with Article V, Section 5.5 of your Contract, the enclosed Change Order transmits Molina Medical Centers, Inc., annual capitation rates for the period October 1, 1998 to September 30,1999. The new rates will appear in your capitation rate beginning June 1999. A check for the difference between the old Contract rates and the new Contract rates, for the period October 1, 1998 until the new rates are reflected in your capitation payments will be mailed in approximately six (6) to eight (8) weeks.

If you have any questions, please contact you contract manager.

Sincerely,

/s/ [illegible] for

Susanne M. Hughes
Acting Chief
Medi-Cal Managed Care Division

Enclosures

[LETTERHEAD OF DEPARTMENT OF HEALTH SERVICES]

CHANGE ORDER NUMBER C1 to CONTRACT No. 95-23637: ADJUSTING THE ANNUAL CAPITATION RATE FOR THE PERIOD OCTOBER 1,1998 TO SEPTEMBER 30, 1999, BY CHANGING CONTRACT SECTIONS 5.3 CAPITATION RATES AND 5.4 CAPITATION RATES CONSTITUTE PAYMENT IN FULL. Issued May 7, 1999.

1. 5.3 CAPITATION RATES

RIVERSIDE COUNTY

FOR THE PERIOD 07/01/95 - 05/31/96

GROUP	AID CODES	RATE
Family	01, 02, 08, 30, 32, 33, 35, 38, 39, 3A, 3C, 3P, 3R, 40, 42, 4C, 4K, 54, 59, 5K	$ 74.70
Disabled	20, 24, 26, 28, 36, 60, 64, 66, 68, 6A, 6C.	$ 181.61
Aged	10, 14, 16, 18,	$ 110.37
Child	03, 04, 45, 82	$ 68.51
Adult	86	$ 492.78

RIVERSIDE COUNTY

FOR THE PERIOD 06/01/96 - 09/30/97

GROUP	AID CODES	RATE
Family	01, 02, 08, 30, 32, 33, 34, 35, 38, 39, 3A, 3C, 3P, 3R, 40, 42, 4C, 4K, 54, 59, 5K	$ 76.39
Disabled	20, 24, 26, 28, 36, 60, 64, 66, 68, 6A, 6C,	$ 178.77
Aged	10, 14, 16, 18,	$ 114.62
Child	03, 04, 45, 82	$ 67.74
Adult	86	$ 509.94

SAN BERNARDINO COUNTY

FOR THE PERIOD 07/01/95 - 05/31/96

GROUP	AID CODES	RATE
Family	01, 02, 08, 30, 32, 33, 34, 35, 38, 39, 3A, 3C, 3P, 3R, 40, 42, 4C, 4K, 54, 59, 5K	$ 70.01
Disabled	20, 24, 26, 28, 36, 60, 64, 66, 68, 6A, 6C.	$ 177.15
Aged	10, 14, 16, 18,	$ 117.66
Child	03, 04, 45, 82	$ 67.91
Adult	86	$ 536.02

SAN BERNARDINO COUNTY

FOR THE PERIOD 06/01/96 - 09/30/97

GROUP	AID CODES	RATE
Family	01, 02, 08, 30, 32, 33, 34, 35, 38, 39, 3A, 3C, 3P, 3R, 40, 42, 4C, 4K, 54, 59, 5K	$ 71.59
Disabled	20, 24, 26, 28, 36, 60, 64, 66, 68, 6A, 6C.	$ 174.45
Aged	10, 14, 16, 18,	$ 121.76
Child	03, 04, 45, 82	$ 67.17
Adult	86	$ 554.73

RIVERSIDE COUNTY

FOR THE PERIOD 10/01/97 - 09/30/98

GROUP	AID CODES	RATE
Family	01, 0A, 02, 08, 30, 32, 3G, 33, 3H, 34, 35, 38, 39, 3A, 3C, 3N, 3P, 3R, 3U, 3R, 40, 42, 54, 59, 7X; CalWORKS: 3E, 3L, 3M	$ 75.91
Disabled	20, 24, 26, 28, 36, 60, 64, 66, 68, 6A, 6C, 6N, 6P, 6R	$ 204.96
Aged	10, 14, 16, 18.	$ 162.29
Child	03, 04, 45, 4C, 4K, 5K, 82	$ 79.33
Adult	86	$ 515.67
AIDS Beneficiary Rate		$ 1021.49

SAN BERNARDINO COUNTY

For the Period 10/01/97 - 09/30/98

GROUP	AID CODES	RATE
Family	01, OA, 02, 08, 30, 32, 3G, 33, 3H, 34, 35, 38, 39, 3A, 3C, 3N, 3P, 3R, 3U, 3R, 40, 42, 54, 59, 7X; CalWORKS: 3E, 3L, 3M	$ 74.04
Disabled	20, 24, 26, 28, 36, 60, 64, 66, 68, 6A, 6C, 6N, 6P, 6R	$ 217.87
Aged	10, 14, 16, 18,	$ 167.25
Child	03, 04, 45, 4C, 4K, 5K, 82	$ 79.42
Adult	86	$ 531.42
AIDS Beneficiary Rate		$ 1072.78

RIVERSIDE COUNTY

For the Period 10/01/98 - 09/30/99

GROUP	AID CODES	RATE
Family	01, OA, 02, 08, 30, 32, 3G, 33, 3H, 34, 35, 38, 39, 3A, 3C, 3N, 3P, 3R, 3U, 3R, 40, 54, 59, 7X; CalWORKS: 3E, 3L, 3M	$ 78.73
Disabled	20, 24, 26, 28, 36, 60, 64, 66,68, 6A, 6C, 6N, 6P, 6R	$ 222.61
Aged	10, 14, 16, 18,	$ 160.47
Child	03, 04, 45, 4C, 4K, 5K, 82	$ 93.09
Adult	86	$ 706.77
AIDS Beneficiary Rate		$ 962.42

SAN BERNARDINO COUNTY

For the Period 10/01/98 - 09/30/99

GROUP	AID CODES	RATE
Family	01, OA, 02, 08, 30, 32, 3G, 33, 3H, 34, 35, 38, 39, 3A, 3C, 3N, 3P, 3R, 3U, 3R, 40, 54, 59, 7X: CalWORKS: 3E, 3L, 3M	$ 80.48
Disabled	20, 24, 26, 28, 36, 60, 64, 66, 68, 6A, 6C, 6N, 6P, 6R	$ 233.49
Aged	10, 14, 16, 18,	$ 163.77
Child	03, 04, 45, 4C, 4K, 5K, 82	$ 106.43
Adult	86	$ 790.89
AIDS Beneficiary Rate		$ 995.00

In the future, DHS may be splitting existing aid codes into new aid codes. The new split aid codes will be in the same aid code group category as the original aid code. If DHS establishes new aid codes by splitting existing aid codes, Contractor agrees to accept Eligible Beneficiaries with these new aid codes as Members and to provide covered services to these Members at the monthly capitation rate specified for the original aid code. The Department shall confirm all aid code splits, and the rates of payment for such new aid codes, in writing to Contractors as soon as practicable after such aid code splits occur.

All other terms, conditions, and provisions contained in Section 5.3 remain unchanged.

3. 5.4 CAPITATION RATES CONSTITUTE PAYMENT IN FULL.

The actuarial basis for the determination of the capitation payment rates is outlined in Attachment 1 (consisting of 12 pages).

All other terms, conditions, and provisions contained in Section 5.4 remain unchanged.

Plan Name:	Molina Medical Center	Plan #:	355	Date:	04-May-99
County:	Riverside	Plan Type:	Commercial Plan	Base Period:	FY 96/97
Aid Code Grouping:	Family				

CI for 95-23637
The Rate Period is October 1, 1998 to September 30, 1999 Capitation Payments at the Beginning of the Month Attachment 1

Coverages	
CCS Indicated Claims	NOT Covered by the Plan
Mental Health Outpatient Services	NOT Covered by the Plan
Mental Health Pharmacy Costs	NOT Covered by the Plan
Mental Health Hospital Inpatient Services	NOT Covered by the Plan
Eyewear	NOT Covered by the Plan
Heroin Detoxification	NOT Covered by the Plan
AIDS Waiver Services	NOT Covered by the Plan
Adult Day Health Care	NOT Covered by the Plan
Chiropractor/Acupuncture	NOT Covered by the Plan
Local Education Authority	NOT Covered by the Plan
Alphafeto Protein Testing	NOT Covered by the Plan
Long Term Care for month of entry plus one	Covered by the Plan
Long Term Care after month of entry plus one	NOT Covered by the Plan
Special AIDS drugs	NOT Covered by the Plan

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care
1. Average Cost Per Unit	$ 69.46	$ 19.88	$ 864.71	$ 16.16	$ 812.04
2. Units per Eligible	4.014	4.683	0.373	2.146	0.004
3. Addt'l Capitation Amts.	$ 0.37	$ 0.05	$ 4.62	$ 0.01	$ 0.00
Cost per Elig. per Mo.	$ 23.60	$ 7.81	$ 31.50	2.90	$ 0.27
Adjustments					
a. Demographics	1.004	0.976	1.023	1.002	1.000
b. Area	1.043	1.000	1.000	1.000	1.000
c. Coverages	0.975	0.992	0.968	0.956	0.995
d. Interest	0.995	0.995	0.995	0.995	0.995
Adjusted Base Cost	$ 23.97	$ 7.52	$ 31.04	$ 2.76	$ 0.27
3. Legislative Adjs.	1.053	1.053	0.998	1.023	1.141
4. Trend Adjustments					
a. Cost per Unit	1.000	1.100	1.050	1.000	1.000
b. Units per Eligible	0.950	1.000	1.050	0.950	1.050
Projected Cost per Eligible	$ 23.98	$ 8.71	$ 34.15	$ 2.68	$ 0.32
5. Stop Loss Reins.		Amount	$ 0		Rate
6. CHDP					
7. Fee-for-Service Adj.					
Capitation Rate With FQHC Increment		$ 78.73 /Without		$ 78.41	

Rate Calculation	Other	FFSE	FQHC Increment	Total
1. Average Cost Per Unit	$ 20.09	$ 68.39	$ 24.41	
2. Units per Eligible	3.532	0.168	0.168	
3. Addt'l Capitation Amts.	$ 0.00	$ 0.00	$ 0.00	
Cost per Elig. per Mo.	$ 5.91	$ 0.96	$ 0.34	$ 73.29
Adjustments				
a. Demographics	0.985	0.994	0.994	
b. Area	1.000	1.000	1.000	
c. Coverages	0.833	0.935	0.935	
d. Interest	0.995	0.995	0.995	
Adjusted Base Cost	$ 4.82	$ 0.89	$ 0.31	$ 71.58
3. Legislative Adjs.	1.046	1 027	1.027	
4. Trend Adjustments				
a. Cost per Unit	0.950	1.000	1.000	
b. Units per Eligible	1.050	1.000	1.000	
Projected Cost per Eligible	$ 5.03	$ 0.91	$ 0.32	$ 76.10
5. Stop Loss Reins.	0.0%		Premium	0.00
6. CHDP				5.06
7. Fee-for-Service Adj.	3.0%			(2.43)
Capitation Rate With FQHC Increment				

Plan Name:	Molina Medical Center	Plan #:	355	Date:	04-May-99
County:	Riverside	Plan Type:	Commercial Plan	Base Period:	FY 96/97
Aid Code Grouping:	Aged				

CI for 95-23637
Attachment 1

The Rate Period is October 1, 1998 to September 30, 1999   Capitation Payments at the Beginning of the Month

Coverages

Coverage	Status
CCS Indicated Claims	NOT Covered by the Plan
Mental Health Outpatient Services	NOT Covered by the Plan
Mental Health Pharmacy Costs	NOT Covered by the Plan
Mental Health Hospital Inpatient Services	NOT Covered by the Plan
Eyewear	NOT Covered by the Plan
Heroin Detoxification	NOT Covered by the Plan
AIDS Waiver Services	NOT Covered by the Plan
Adult Day Health Care	NOT Covered by the Plan
Chiropractor/Acupuncture	NOT Covered by the Plan
Local Education Authority	NOT Covered by the Plan
Alphafeto Protein Testing	NOT Covered by the Plan
Long Term Care for month of entry plus one	Covered by the Plan
Long Term Care after month of entry plus one	NOT Covered by the Plan
Special AIDS drugs	NOT Covered by the Plan

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care
1. Average Cost Per Unit	$ 48.90	$ 32.71	$ 287.24	$ 10.02	$ 77.33
2. Units per Eligible	4.472	21.914	1.265	3.306	2.016
3. Addt'l Capitation Amts.	$ 1.29	$ 0.00	$ 7.41	$ 0.02	$ 0.00
Cost per Elig. per Mo.	$ 19.51	$ 59.73	$ 37.69	$ 2.78	$ 12.99
Adjustments					
a. Demographics	0.955	1.019	0.957	0.970	1.039
b. Area	1.043	1.000	1.000	1.000	1.000
c. Coverages	0.981	0.996	0.997	0.986	0.997
d. Interest	0.995	0.995	0.995	0.995	0.995
Adjusted Base Cost	$ 18.97	$ 60.32	$ 35.78	$ 2.65	$ 13.39
3. Legislative Adjs.	0.939	1.049	0.926	0.931	1.140
4. Trend Adjustments					
a. Cost per Unit	1.100	1.100	1.100	1.050	1.000
b. Units per Eligible	1.100	1.155	1.100	1.100	1.000
Projected Cost per Eligible	$ 21.55	$ 80.39	$ 40.09	$ 2.85	$ 15.26
5 Stop Loss Reins.		Amount	$ 0		Rate
6. CHDP					
7. Fee for Service Adj.					
Capitation Rate With FQHC Increment		$ 160.47 /Without		$ 160.47	

Rate Calculation	Other	FFSE	FQHC Increment	Total
1. Average Cost Per Unit	$ 6.41	$ 28.59	$ 0.00	
2. Units per Eligible	12.862	0.132	0.132	
3. Addt'l Capitation Amts.	$ 0.00	$ 0.00	$ 0.00	
Cost per Elig. per Mo.	$ 6.87	$ 0.31	$ 0.00	$ 139.88
Adjustments				
a. Demographics	1,025	0.970	0.970	
b. Area	1.000	1.000	1.000	
c. Coverages	0.791	0.603	0.603	
d. Interest	0.995	0.995	0.995	
Adjusted Base Cost	$ 5.54	$ 0.18	$ 0.00	$ 136.83
3. Legislative	0.927	0.926	0.926	
4. Trend Adjustments				
a. Cost per Unit	1.050	1.000	1.000	
b. Units per Eligible	0.950	1.000	1.000	
Projected Cost per Eligible	$ 5.12	$ 0.17	$ 0.00	$ 165.43
5 Stop Loss Reins.	0.0%		Premium	0.00
6. CHDP				0.00
7. Fee for Service Adj.	-3.0%			(4.96)
Capitation Rate With FQHC Increment				

Plan Name:	Molina Medical Center	Plan #:	355	Date:	04-May-99
County:	Riverside	Plan Type:	Commercial Plan	Base Period:	FY 96/97
Aid Code Grouping:	Disabled				

CI for 95-23637
Attachment 1

The Rate Period is October 1, 1998 to September 30, 1999   Capitation Payments at the Beginning of the Month

Coverages

Coverage	Status
CCS Indicated Claims	NOT Covered by the Plan
Menial Health Outpatient Services	NOT Covered by the Plan
Mental Health Pharmacy Costs	NOT Covered by the Plan
Mental Health Hospital Inpatient Services	NOT Covered by the Plan
Eyewear	NOT Covered by the Plan
Heroin Detoxification	NOT Covered by the Plan
AIDS Waiver Services	NOT Covered by the Plan
Adult Day Health Care	NOT Covered by the Plan
Chiropractor/Acupuncture	NOT Covered by the Plan
Local Education Authority	NOT Covered by the Plan
Alphafeto Protein Testing	NOT Covered by the Plan
Long Term Care for month of entry plus one	Covered by the Plan
Long Term Care after month of entry plus one	NOT Covered by the Plan
Special AIDS drugs	NOT Covered by the Plan

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care
1. Average Cost Per Unit	$ 46.41	$ 39.70	$ 485.15	$ 12.37	$ 139.87
2. Units per Eligible	6.873	26.861	1.556	5.050	0.459
3. Addt'l Capitation Amts.	$ 2.96	$ 0.09	$ 9.89	$ 0.02	$ 0.00
Cost per Elig. per Mo.	$ 29.54	$ 88.96	$ 72.80	$ 5.23	$ 5.35
Adjustments					
a. Demographics	0.983	0.989	0.981	0.998	1.000
b. Area	1.043	1.000	1.000	1.000	1.000
c. Coverages	0.900	0.875	0.920	0.973	0.995
d. Interest	0.995	0.995	0.995	0.995	0.995
Adjusted Base Cost	$ 27.12	$ 76.60	$ 65.37	$ 5.05	$ 5.30
3. Legislative Adjs.	0.941	1.043	0.919	0.931	1.130
4. Trend Adjustments					
a. Cost per Unit	1.000	1.100	1.050	1.000	1.100
b. Units per Eligible	1.100	1.210	1.050	1.045	0.950
Projected Cost per Eligible	$ 28.07	$ 106.34	$ 66.23	$ 4.91	$ 6.26
5 Stop Loss Reins.		Amount	$ 0		Rate
6 CHDP					
7. Fee-for-Service Adj.					
Capitation Rate With FQHC Increment		$ 222.61 /Without		$ 222.61	

Rate Calculation	Other	FFSE	FQHC Increment	Total
1. Average Cost Per Unit	$ 10.16	$ 66.52	$ 0.00	
2. Units per Eligible	21.959	0.216	0.216	
3. Addt'l Capitation Amts.	$ 0.00	$ 0.00	$ 0.00	
Cost per Elig. per Mo.	$ 18.59	$ 1.20	$ 0.00	$ 221.67
Adjustments				
a. Demographics	1.015	0.987	0.987	
b. Area	1.000	1.000	1.000	
c. Coverages	0.878	0.863	0.883	
d. Interest	0.995	0.995	0.995	
Adjusted Base Cost	$ 16.48	$ 1.02	$ 0.00	$ 196.94
3. Legislative Adjs.	0.923	0.932	0.932	
4. Trend Adjustments				
a. Cost per Unit	1.100	1.000	1.000	
b. Units per Eligible	1.000	1.000	1.000	
Projected Cost per Eligible	$ 16.73	$ 0.95	$ 0.00	$ 229.49
5 Stop Loss	0.0%		Premium	0.00
6 CHDP				0.00
7. Fee for Service Adj.	-3.0%			(6.88)
Capitation Rate With FQHC Increment				

Plan Name:	Molina Medical Center	Plan #:	355	Date:	04-May-99
County:	Riverside	Plan Type:	Commercial Plan	Base Period:	FY 96/97
Aid Code Grouping:	Child				

CI for 95-23637
Attachment 1

The Rate Period is October 1,1998 to September 30, 1999 Capitation Payments at the Beginning of the Month

Coverages

Coverage	Status
CCS Indicated Claims	NOT Covered by the Plan
Menial Health Outpatient Services	NOT Covered by the Plan
Mental Hearth Pharmacy Costs	NOT Covered by the Plan
Mental Health Hospital Inpatient Services	NOT Covered by the Plan
Eyewear	NOT Covered by the Plan
Heroin Detoxification	NOT Covered by the Plan
AIDS Waiver Services	NOT Covered by the Plan
Adult Day Health Care	NOT Covered by the Plan
Chiropractor/Acupuncture	NOT Covered by the Plan
Local Education Authority	NOT Covered by the Plan
Alphafeto Protein Testing	NOT Covered by the Plan
Long Term Care for month of entry plus one	Covered by the Plan
Long Term Care after month of entry plus one	NOT Covered by the Plan
Special AIDS drugs	NOT Covered by the Plan

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care
1. Average Cost Per Unit	$ 67.42	$ 13.64	$ 889.41	$ 16.21	$ 469.38
2. Units per Eligible	3.999	3.411	0.465	1.516	0.007
3. Addt'l Capitation Amts.	$ 0.23	$ 0.03	$ 2.90	$ 0.00	$ 0.00
Cost per Elig. per Mo.	$ 22.70	$ 3.91	$ 37.36	$ 2.05	$ 0.27
Adjustments					
a. Demographics	1.181	1.019	1.321	1.114	1.000
b. Area	1.043	1.000	1.000	1.000	1.000
c. Coverages	0.974	0.984	0.952	0.973	0.996
d. Interest	0.995	0.995	0.995	0.995	0.995
Adjusted Base Cost	$ 27.10	$ 3.90	$ 46.75	$ 2.21	$ 0.27
3. Legislative Adjs.	1.076	1.047	0.999	1.024	1.134
4. Trend Adjustments					
a. Cost per Unit	1.000	1.100	1.050	1.000	1.000
b. Units per Eligible	0.950	1.000	1.050	0.950	1.050
Projected Cost per Eligible	$ 27.70	$ 4.49	$ 51.49	$ 2.15	$ 0.32
5. Stop Loss Reins.		Amount	$ 0		Rate
6. CHDP					
7. Fee-for-Service Adj.					
Capitation Rate With FQHC Increment		$ 93.09 /Without		$ 92.75	

Rate Calculation	Other	FQHC FFSE	Increment	Total
1. Average Cost Per Unit	$ 20.69	$ 68.39	$ 24.41	
2. Units per Eligible	1.958	0.168	0.168	
3. Addt'l Capitation Amts.	$ 0.00	$ 0.00	$ 0.00	
Cost per Elig. per Mo.	$ 3.38	$ 0.96	$ 0.34	$ 70.97
Adjustments				
a. Demographics	1.165	1.003	1.003	
b. Area	1.000	1.000	1.000	
c. Coverages	0.815	0.970	0.970	
d. Interest	0.995	0.995	0.995	
Adjusted Base Cost	$ 3.19	$ 0.93	$ 0.33	$ 84.68
3. Legislative Adjs.	1.090	1.031	1.031	
4. Trend Adjustments				
a. Cost per Unit	0.950	1.000	1.000	
b. Units per Eligible	1.050	1.000	1.000	
Projected Cost per Eligible	$ 3.47	$ 0.96	$ 0.34	$ 90.92
5. Stop Loss Reins.	0.0%		Premium	0.00
6. CHDP				$ 5.04
7. Fee-for-Service Adj.	-3.0%			(2.87)
Capitation Rate With FQHC Increment				

Plan Name:	Molina Medical Center	Plan #:	355	Date:	04-May-99
County:	Riverside	Plan Type:	Commercial Plan	Base Period:	FY 96/97
Aid Code Grouping:	Adult				

The Rate Period is October 1,1998 to September 30, 1999 Capitation Payments at the Beginning of the Month

CI for 95-23637
Attachment 1

Coverages

CCS Indicated Claims	NOT Covered by the Plan
Mental Health Outpatient Services	NOT Covered by the Plan
Mental Health Pharmacy Costs	NOT Covered by the Plan
Mental Health Hospital Inpatient Services	NOT Covered by the Plan
Eyewear	NOT Covered by the Plan
Heroin Detoxification	NOT Covered by the Plan
AIDS Waiver Services	NOT Covered by the Plan
Adult Day Health Care	NOT Covered by the Plan
Chiropractor/Acupuncture	NOT Covered by the Plan
Local Education Authority	NOT Covered by the Plan
Alphafeto Protein Testing	NOT Covered by the Plan
Long Term Care for month of entry plus one	Covered by the Plan
Long Term Care after month of entry plus one	NOT Covered by the Plan
Special AIDS drugs	NOT Covered by the Plan

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care
1. Average Cost Per Unit	$ 90.48	$ 17.11	$ 964.66	$ 15.76	$ 812.04
2. Units per Eligible	21.383	5.818	5.446	4.679	0.000
3. Addt'l Capitation Amts.	$ 0.37	$ 0.06	$ 35.62	$ 0.08	$ 0.00
Cost per Elig. per Mo.	$ 161.60	$ 8.36	$ 473.41	$ 6.23	$ 0.00
Adjustments					
a. Demographics	1.000	1.000	1.000	1.000	1.000
b. Area	1.043	1.000	1.000	1.000	1.000
c. Coverages	0.999	0.999	0.999	0.989	1.000
d. Interest	0.995	0.995	0.995	0.995	0.995
Adjusted Base Cost	$ 167.54	$ 8.31	$ 470.57	$ 6.13	$ 0.00
3 Legislative Adjs.	1.029	1.054	1.000	1.022	1.102
4. Trend Adjustments					
a. Cost per Unit	1.000	1.100	1.050	1.000	1.000
b. Units per Eligible	0.950	1.000	1.050	0.950	1.050
Projected Cost per Eligible	$ 163.78	$ 9.63	$ 518.60	$ 5.95	$ 0.00
5. Stop Loss Reins.		Amount	$ 0		Rate
6. CHDP					
7. Fee-for-Service Adj.					
Capitation Rate With FQHC Increment		$ 706.77 /Without		$ 705.26	

Rate Calculation	Other	FFSE	FQHC Increment	Total
1. Average Cost Per Unit	$ 36.13	$ 68.39	$ 24.41	
2. Units per Eligible	10.172	0.735	0.735	
3. Addt'l Capitation Amts.	$ 0.00	$ 0.00	$ 0.00	
Cost per Elig. per Mo.	$ 30.63	$ 4.19	$ 1.50	$ 685.92
Adjustments				
a. Demographics	1.000	1.000	1.000	
b. Area	1.000	1.000	1.000	
c. Coverages	0.809	0.995	0.995	
d. Interest	0.995	0.995	0.995	
Adjusted Base Cost	$ 24.66	$ 4.15	$ 1.49	$ 682.85
3 Legislative Adjs.	1.004	1.015	1.015	
4. Trend Adjustments				
a. Cost per Unit	0.950	1.000	1.000	
b. Units per Eligible	1.050	1.000	1.000	
Projected Cost per Eligible	$ 24.70	$ 4.21	$ 1.51	$ 728.58
5. Stop Loss Reins.	0.0%		Premium	0.00
6. CHDP				0.00
7. Fee-for-Service Adj.	-3.0%			(21.81)
Capitation Rate With FQHC Increment				

Plan Name:	Molina Medical Center	Plan #:	355	Date:	04-May-99
County:	Riverside	Plan Type:	Commercial Plan	Base Period:	FY 96/97
Aid Code Grouping:	AIDS				

The Rate Period is October 1,1998 to September 30, 1999   Capitation Payments at the Beginning of the Month   CI for 95-23637 Attachment 1

Coverages

CCS Indicated Claims	NOT Covered by the Plan
Mental Health Outpatient Services	NOT Covered by the Plan
Mental Health Pharmacy Costs	NOT Covered by the Plan
Mental Health Hospital Inpatient Services	NOT Covered by the Plan
Eyewear	NOT Covered by the Plan
Heroin Detoxification	NOT Covered by the Plan
AIDS Waiver Services	NOT Covered by the Plan
Adult Day Health Care	NOT Covered by the Plan
Chiropractor/Acupuncture	NOT Covered by the Plan
Local Education Authority	NOT Covered by the Plan
Alphafeto Protein Testing	NOT Covered by the Plan
Long Term Care for month of entry plus one	Covered by the Plan
Long Term Care after month of entry plus one	NOT Covered by the Plan
Special AIDS drugs	NOT Covered by the Plan

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care
1 Average Cost Per Unit	$ 32.67	$ 126.04	$ 485.15	$ 13.79	$ 139.87
2. Units per Eligible	26.305	74.792	3.169	9.882	0.000
3. Addt'l Capitation Amts.	$ 2.96	$ 0.09	$ 9.89	$ 0.02	$ 0.00
Cost per Elig. per Mo.	$ 74.57	$ 785.68	$ 138.01	$ 11.38	$ 0.00
Adjustments					
a. Demographics	1.000	1.000	1.000	1.000	1.000
b. Area	1.043	1.000	1.000	1.000	1.000
c. Coverages	0.918	0.648	0.957	0.992	0.998
d. Interest	0.995	0.995	0.995	0.995	0.995
Adjusted Base Cost	$ 71.04	$ 506.56	$ 131.42	$ 11.23	$ 0.00
3. Legislative Adjs.	0.963	1.006	0.977	0.982	1.186
4. Trend Adjustments					
a. Cost per Unit	1.000	1.100	1.050	1.000	1.100
b. Units per Eligible	1.100	1.210	1.050	1.045	0.950
Projected Cost per Eligible	$ 75.25	$ 678.28	$ 141.56	$ 11.52	$ 0.00
5 Stop Loss Reins.		Amount	$ 0		Rate
6. CHDP					
7. Fee-for-Service Adj.					
Capitation Rate With FQHC Increment		$ 962.42 /Without		$ 962.42	

Rate Calculation	Other	FFSE	FQHC Increment	Total
1 Average Cost Per Unit	$ 42.30	$ 66.52	$ 0.00	
2. Units per Eligible	36.392	0.628	0.628	
3. Addt'l Capitation Amts.	$ 0.00	$ 0.00	$ 0.00	
Cost per Elig. per Mo.	$ 128.28	$ 3.46	$ 0.00	$ 1,141.38
Adjustments				
a. Demographics	1.000	1.000	1.000	
b. Area	1.000	1.000	1.000	
c. Coverages	0.599	0.951	0.951	
d. Interest	0.995	0.995	0.995	
Adjusted Base Cost	$ 76.46	$ 3.29	$ 0.00	$ 800.00
3. Legislative Adjs.	0.979	0.984	0.984	
4. Trend Adjustments				
a. Cost per Unit	1.100	1.000	1.000	
b. Units per Eligible	1.000	1.000	1.000	
Projected Cost per Eligible	$ 82.34	$ 3.24	$ 0.00	$ 992.19
5 Stop Loss Reins.	0.0%		Premium	0.00
6. CHdP				0.00
7. Fee-for-Service Adj.	-3.0%			29.77
Capitation Rate With FQHC Increment				

Plan Name:	Molina Medical Center	Plan #:	356	Date:	04-May-99
County:	San Bernardino	Plan Type:	Commercial Plan	Base Period:	FY 96/97
Aid Code Grouping:	Family				

CI for 95-23637
Attachment 1

The Rate Period is October 1,1998 to September 30, 1999 Capitation Payments at the Beginning of the Month

Coverages

Coverage	Status
CCS Indicated Claims	NOT Covered by the Plan
Mental Health Outpatient Services	NOT Covered by the Plan
Mental Health Pharmacy Costs	NOT Covered by the Plan
Mental Health Hospital Inpatient Services	NOT Covered by the Plan
Eyewear	NOT Covered by the Plan
Heroin Detoxification	NOT Covered by the Plan
AIDS Waiver Services	NOT Covered by the Plan
Adult Day Health Care	NOT Covered by the Plan
Chiropractor/Acupuncture	NOT Covered by the Plan
Local Education Authority	NOT Covered by the Plan
Alphafeto Protein Testing	NOT Covered by the Plan
Long Term Care for month of entry plus one	Covered by the Plan
Long Term Care after month of entry plus one	NOT Covered by the Plan
Special AIDS drugs	NOT Covered by the Plan

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care
1. Average Cost Per Unit	$ 69.46	$ 19.88	$ 978.02	$ 16.16	$ 812.04
2. Units per Eligible	4.050	4.683	0.373	2.146	0.004
3. Addt'l Capitation Amts.	$ 0.37	$ 0.05	$ 4.62	$ 0.01	$ 0.00
Cost per Elig. per Mo.	$ 23.81	$ 7.81	$ 35.02	$ 2.90	$ 0.27
Adjustments					
a. Demographics	0.997	0.993	0.977	0.987	1.000
b. Area	1.043	1.000	1.000	1.000	1.000
c. Coverages	0.975	0.992	0.968	0.956	0.995
d. Interest	0.995	0.995	0.995	0.995	0.995
Adjusted Base Cost	$ 24.02	$ 7.65	$ 32.95	$ 2.72	$ 0.27
3. Legislative Adjs.	1.053	1.053	0.998	1.023	1.141
4. Trend Adjustments					
a. Cost per Unit	1.000	1.100	1.050	1.000	1.000
b. Units per Eligible	0.950	1.000	1.050	0.950	1.050
Projected Cost per Eligible	$ 24.03	$ 8.86	$ 36.25	$ 2.64	$ 0.32
5. Stop Loss Reins.		Amount	$ 0		Rate
6. CHDP					
7. Fee-for-Service Adj.					
Capitation Rate With FQHC Increment		$ 80.48 /Without		$ 80.41	

Rate Calculation	Other	FFSE	FQHC Increment	Total
1. Average Cost Per Unit	$ 20.09	$ 68.10	$ 7.33	
2. Units per Eligible	3.532	0.132	0.132	
3. Addt'l Capitation Amts.	$ 0.00	$ 0.00	$ 0.00	
Cost per Elig. per Mo.	$ 5.91	$ 0.75	$ 0.08	$ 76.55
Adjustments				
a. Demographics	0.985	0.992	0.992	
b. Area	1.000	1.000	1.000	
c. Coverages	0.833	0.935	0.935	
d. Interest	0.995	0.995	0.995	
Adjusted Base Cost	$ 4.82	$ 0.69	$ 0.07	$ 73.19
3. Legislative Adjs.	1.046	1.027	1.027	
4. Trend Adjustments				
a. Cost per Unit	0.950	1.000	1.000	
b. Units per Eligible	1.050	1.000	1.000	
Projected Cost per Eligible	$ 5.03	$ 0.71	$ 0.07	$ 77.91
5. Stop Loss Reins.	0.0%		Premium	0.00
6. CHDP				5.06
7. Fee-for-Service Adj.	-3.0%			(2.49)
Capitation Rate With FQHC Increment				

Plan Name:	Molina Medical Center	Plan #:	356	Date:	04-May-99
County:	San Bernardino	Plan Type:	Commercial Plan	Base Period:	FY 96/97
Aid Code Grouping:	Aged				

CI for 95-23637
The Rate Period is October 1,1998 to September 30, 1999 Capitation Payments at the Beginning of the Month Attachment 1

Coverages

Coverage	Status
CCS Indicated Claims	NOT Covered by the Plan
Mental Health Outpatient Services	NOT Covered by the Plan
Mental Health Pharmacy Costs	NOT Covered by the Plan
Mental Health Hospital Inpatient Services	NOT Covered by the Plan
Eyewear	NOT Covered by the Plan
Heroin Detoxification	NOT Covered by the Plan
AIDS Waiver Services	NOT Covered by the Plan
Adult Day Health Care	NOT Covered by the Plan
Chiropractor/Acupuncture	NOT Covered by the Plan
Local Education Authority	NOT Covered by the Plan
Alphafeto Protein Testing	NOT Covered by the Plan
Long Term Care for month of entry plus one	Covered by the Plan
Long Term Care after month of entry plus one	NOT Covered by the Plan
Special AIDS drugs	NOT Covered by the Plan

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care
1. Average Cost Per Unit	$ 48.90	$ 32.71	$ 316.16	$ 10.02	$ 77.33
2. Units per Eligible	4.580	21.914	1.265	3.306	2.016
3. Addt'l Capitation Amts.	$ 1.29	$ 0.00	$ 7.41	$ 0.02	$ 0.00
Cost per Elig. per Mo.	$ 19.95	$ 59.73	$ 40.74	$ 2.78	$ 12.99
Adjustments					
a. Demographics	0.963	1.014	0.962	0.975	1.027
b. Area	1.043	1.000	1.000	1.000	1.000
c. Coverages	0.981	0.996	0.997	0.986	0.997
d. Interest	0.995	0.995	0.995	0.995	0.995
Adjusted Base Cost	$ 19.56	$ 60.02	$ 38.88	$ 2.66	$ 13.23
3. Legislative Adjs.	0.939	1 049	0.926	0.931	1.140
4. Trend Adjustments					
a. Cost per Unit	1.100	1.100	1.100	1.050	1.000
b. Units per Eligible	1.100	1.155	1.100	1.100	1 000
Projected Cost per	$ 22.22	$ 79.99	$ 43.56	$ 2.86	$ 15.08
5. Stop Loss Reins.		Amount	$ 0		Rate
6. CHDP					
7. Fee-for-Service Adj.					
Capitation Rate With FQHC Increment		$ 163.77 /Without		$ 163.77	

Rate Calculation	Other	FFSE	FQHC Increment	Total
1. Average Cost Per Unit	$ 6.41	$ 50.63	$ 0.00	
2. Units per Eligible	12.862	0.024	0.024	
3. Addt'l Capitation Amts.	$ 0.00	$ 0.00	$ 0.00	
Cost per Elig. per Mo.	$ 6.87	$ 0.10	$ 0.00	$ 143.16
Adjustments				
a. Demographics	1.013	0.979	0.979	
b. Area	1.000	1.000	1.000	
c. Coverages	0.791	0.603	0.603	
d. Interest	0.995	0.995	0.995	
Adjusted Base Cost	$ 5.48	$ 0.06	$ 0.00	$ 139.89
3. Legislative Adjs.	0.927	0.926	0.926	
4. Trend Adjustments				
a. Cost per Unit	1. 050	1.000	1.000	
b. Units per Eligible	0.950	1.000	1.000	
Projected Cost per	$ 5.07	$ 0.06	$ 0.00	$ 168.84
5. Stop Loss Reins.	0.0%		Premium	0.00
6. CHDP				0.00
7. Fee-for-Service Adj.				
Capitation Rate With FQHC Increment	-3.0%			(5.07)

Plan Name:	Molina Medical Center	Plan #:	356	Date:	04-May-99
County:	San Bernardino	Plan Type:	Commercial Plan	Base Period:	FY 96/97
Aid Code Grouping:	Disabled				

CI for 95-23637
Attachment 1

The Rate Period is October 1,1998 to September 30, 1999 Capitation Payments at the Beginning of the Month

Coverages

Coverage	Status
CCS Indicated Claims	NOT Covered by the Plan
Mental Health Outpatient Services	NOT Covered by the Plan
Mental Health Pharmacy Costs	NOT Covered by the Plan
Mental Health Hospital Inpatient Services	NOT Covered by the Plan
Eyewear	NOT Covered by (he Plan
Heroin Detoxification	NOT Covered by the Plan
AIDS Waiver Services	NOT Covered by the Plan
Adult Day Health Care	NOT Covered by the Plan
Chiropractor/Acupuncture	NOT Covered by the Plan
Local Education Authority	NOT Covered by the Plan
Alphafeto Protein Testing	NOT Covered by the Plan
Long Term Care for month of entry plus one	Covered by the Plan
Long Term Care after month of entry plus one	NOT Covered by the Plan
Special AIDS drugs	NOT Covered by the Plan

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care
1. Average Cost Per Unit	$ 46.41	$ 39.70	$ 611.26	$ 12.37	$ 139.87
2. Units per Eligible	6.969	26.861	1.556	5.050	0.459
3. Addl'l Capitation Amts.	$ 2.96	$ 0.09	$ 9.89	$ 0.02	$ 0.00
Cost per Elig. per Mo.	$ 29.91	$ 88.96	$ 89.15	$ 5.23	$ 5.35
Adjustments					
a. Demographics	0.980	0.973	0.961	0.998	0.996
b. Area	1.043	1.000	1.000	1.000	1.000
c. Coverages	0.900	0.875	0.920	0.973	0.995
d. Interest	0.995	0.995	0.995	0.995	0.995
Adjusted Base Cost	$ 27.38	$ 75.36	$ 78.43	$ 5.05	$ 5.28
3. Legislative Adjs.	0.941	1.043	0.919	0.931	1.130
4. Trend Adjustments					
a. Cost per Unit	1.000	1.100	1.050	1.000	1.100
b. Units per Eligible	1.100	1.210	1.050	1.045	0.950
Projected Cost per Eligible	$ 28.34	$ 104.62	$ 79.47	$ 4.91	$ 6.23
5. Stop Loss Reins.		Amount	$ 0		Rate
6. CHDP					
7.Fee-for-Service Adj.					
Capitation Rate With FQHC Increment		$ 233.49 /Without		$ 233.49	

Rate Calculation	Other	FFSE	FQHC Increment	Total
1. Average Cost Per Unit	$ 10.16	$ 69.96	$ 0.00	
2. Units per Eligible	21.959	0.120	0.120	
3. Addl't Capitation Amts.	$ 0.00	$ 0.00	$ 0.00	
Cost per Elig. per Mo.	$ 18.59	$ 0.70	$ 0.00	$ 237.89
Adjustments				
a. Demographics	1.006	0.989	0.989	
b. Area	1.000	1.000	1.000	
c. Coverages	0.878	0.863	0.863	
d. Interest	0.995	0.995	0.995	
Adjusted Base Cost	$ 16.34	$ 0.59	$ 0.00	$ 208.43
3. Legislative Adjs.	0.923	0.932	0.932	
4. Trend Adjustments				
a. Cost per Unit	1.100	1.000	1.000	
b. Units per Eligible	1.000	1.000	1.000	
Projected Cost per Eligible	$ 16.59	$ 0.55	$ 0.00	$ 240.71
5. Stop Loss Reins.	0.0%		Premium	0.00
6. CHDP				0.00
7.Fee-for-Service Adj.	-3.0%			(7.22)
Capitation Rate With FQHC Increment				

Plan Name:	Molina Medical Center	Plan #:	356	Date:	04-May-99
County:	San Bernardino	Plan Type:	Commercial Plan	Base Period:	FY 96/97
Aid Code Grouping:	Child				

CI for 95-23637

The Rate Period is October 1,1998 to September 30, 1999 Capitation Payments at the Beginning of the Month Attachment 1

Coverages

Coverage	Status
CCS Indicated Claims	NOT Covered by the Plan
Mental Health Outpatient Services	NOT Covered by the Plan
Mental Health Pharmacy Costs	NOT Covered by the Plan
Mental Health Hospital Inpatient Services	NOT Covered by the Plan
Eyewear	NOT Covered by the Plan
Heroin Detoxification	NOT Covered by the Plan
AIDS Waiver Services	NOT Covered by the Plan
Adult Day Health Care	NOT Covered by the Plan
Chiropractor/Acupuncture	NOT Covered by the Plan
Local Education Authority	NOT Covered by the Plan
Alphafeto Protein Testing	NOT Covered by the Plan
Long Term Care for month of entry plus one	Covered by the Plan
Long Term Care after month of entry plus one	NOT Covered by the Plan
Special AIDS drugs	NOT Covered by the Plan

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care
1. Average Cost Per Unit	$ 67.42	$ 13.64	$ 1,120.53	$ 16.21	$ 469.38
2. Units per Eligible	4.035	3.411	0.465	1.518	0.007
3. Addt'l Capitation Amts.	$ 0.23	$ 0.03	$ 2.90	$ 0.00	$ 0.00
Cost per Elig. per Mo.	$ 22.90	$ 3.91	$ 46.32	$ 2.05	$ 0.27
Adjustments					
a. Demographics	1.212	1.021	1.342	1.157	1.000
b. Area	1.043	1.000	1.000	1.000	1.000
c. Coverages	0.974	0.984	0.952	0.973	0.996
d. Interest	0.995	0.995	0.995	0.995	0.995
Adjusted Base Cost	$ 28.05	$ 3.91	$ 58.88	$ 2.30	$ 0.27
3 Legislative Adjs	1.076	1.047	0.999	1.024	1.134
4. Trend Adjustments					
a. Cost per Unit	1.000	1.100	1.050	1.000	1.000
b. Units per Eligible	0.950	1.000	1.050	0.950	1.050
Projected Cost per Eligible	$ 28.67	$ 4.50	$ 64.85	$ 2.24	$ 0.32
5. Stop Loss Reins.		Amount	$ 0		Rate
6. CHDP					
7.Fee-for-Service Adj.					
Capitation Rate With FQHC Increment		$ 106.43 /Without		$ 106.35	

Rate Calculation	Other	FFSE	FQHC Increment	Total
1. Average Cost Per Unit	$ 20.69	$ 68.10	$ 7.33	
2. Units per Eligible	1.958	0.132	0.132	
3. Addt'l Capitation Amts.	$ 0.00	$ 0.00	$ 0.00	
Cost per Elig. per Mo.	$ 3.38	$ 0.75	$ 0.08	$ 79.68
Adjustments				
a. Demographics	1.080	1.084	1.084	
b. Area	1.000	1.000	1.000	
c. Coverages	0.815	0.970	0.970	
d. Interest	0.995	0.995	0.995	
Adjusted Base Cost	$ 2.96	$ 0.78	$ 0.08	$ 97.23
3 Legislative Adjs	1.090	1.031	1.031	
4. Trend Adjustments				
a. Cost per Unit	0.950	1.000	1.000	
b. Units per Eligible	1.050	1.000	1.000	
Projected Cost per Eligible	$ 3.22	$ 0.80	$ 0.08	$ 104.68
5. Stop Loss Reins.	0.0%		Premium	0.00
6. CHDP				5.04
7.Fee-for-Service Adj.	-3.0%			(3.29)
Capitation Rate With FQHC Increment				

Plan Name:	Molina Medical Center	Plan #:	356	Date:	04-May-99
County:	Riverside	Plan Type:	Commercial Plan	Base Period:	FY 96/97
Aid Code Grouping:	Adult				

The Rate Period is October 1,1998 to September 30, 1999 Capitation Payments at the Beginning of the Month

CI for 95-23637
Attachment 1

Coverages

Coverage	Status
CCS Indicated Claims	NOT Covered by the Plan
Mental Health Outpatient Services	NOT Covered by the Plan
Mental Health Pharmacy Costs	NOT Covered by the Plan
Mental Health Hospital Inpatient Services	NOT Covered by the Plan
Eyewear	NOT Covered by the Plan
Heroin Detoxification	NOT Covered by the Plan
AIDS Waiver Services	NOT Covered by the Plan
Adult Day Health Care	NOT Covered by the Plan
Chiropractor/Acupuncture	NOT Covered by the Plan
Local Education Authority	NOT Covered by the Plan
Alphafeto Protein Testing	NOT Covered by the Plan
Long Term Care for month of entry plus one	Covered by the Plan
Long Term Care after month of entry plus one	NOT Covered by the Plan
Special AIDS drugs	NOT Covered by the Plan

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care
1. Average Cost Per Unit	$ 90.48	$ 17.11	$ 1,140.81	$ 15.76	$ 812.04
2. Units per Eligible	21.541	5.818	5.446	4.679	0.000
3. Addt'l Capitation Amts.	$ 0.37	$ 0.06	$ 35.62	$ 0.08	$ 0.00
Cost per Elig. per Mo.	$ 162.79	$ 8.36	$ 553.36	$ 6.23	$ 0.00
Adjustments					
a. Demographics	1.000	1.000	1.000	1.000	1.000
b. Area	1.043	1.000	1.000	1.000	1.000
c. Coverages	0.999	0.999	0.999	0.989	1.000
d. Interest	0.995	0.995	0.995	0.995	0.995
Adjusted Base Cost	$ 168.77	$ 8.31	$ 550.04	$ 6.13	$ 0.00
3. Legislative Adjs.	1.029	1.054	1.000	1.022	1.102
4. Trend Adjustments					
a. Cost per Unit	1.000	1.100	1.050	1.000	1.000
b. Units per Eligible	0.950	1.000	1.050	0.950	1.050
Projected Cost per Eligible	$ 164.98	$ 9.63	$ 606.42	$ 5.95	$ 0.00
5. Stop Loss Reins.		Amount	$ 0		Rate
6. CHDP					
7.Fee-for-Service Adj.					
Capitation Rate With FQHC Increment		$ 790.89 /Without		$ 790.53	

Rate Calculation	Other	FFSE	FQHC Increment	Total
1. Average Cost Per Unit	$ 36.13	$ 68.10	$ 7.33	
2. Units per Eligible	10.172	0.577	0.577	
3. Addt'l Capitation Amts.	$ 0.00	$ 0.00	$ 0.00	
Cost per Elig. per Mo.	$ 30.63	$ 3.28	$ 0.35	$ 765.00
Adjustments				
a. Demographics	1.000	1.000	1.000	
b. Area	1.000	1.000	1.000	
c. Coverages	0.809	0.995	0.995	
d. Interest	0.995	0.995	0.995	
Adjusted Base Cost	$ 24.66	$ 3.25	$ 0.35	$ 761.51
3. Legislative Adjs.	1.004	1.015	1.015	
4. Trend Adjustments				
a. Cost per Unit	0.950	1.000	1.000	
b. Units per Eligible	1.050	1.000	1.000	
Projected Cost per Eligible	$ 24.70	$ 3.30	$ 0.36	$ 815.34
5. Stop Loss Reins.	0.0%		Premium	0.00
6. CHDP				0.00
7.Fee-for-Service Adj.	-3.0%			(24.45)
Capitation Rate With FQHC Increment				

Plan Name:	Molina Medical Center	Plan #:	356	Date:	04-May-99
County:	San Bernardino	Plan Type:	Commercial Plan	Base Period:	FY 96/97
Aid Code Grouping:	AIDS				

CI for 95-23637

The Rate Period Is October 1,1998 to September 30, 1999 Capitation Payments at the Beginning of the Month Attachment 1

Coverages

CCS Indicated Claims	NOT Covered by the Plan
Mental Health Outpatient Services	NOT Covered by the Plan
Mental Health Pharmacy Costs	NOT Covered by the Plan
Mental Health Hospital Inpatient Services	NOT Covered by the Plan
Eyewear	NOT Covered by the Plan
Heroin Detoxification	NOT Covered by the Plan
AIDS Waiver Services	NOT Covered by the Plan
Adult Day Health Care	NOT Covered by the Plan
Chiropractor/Acupuncture	NOT Covered by the Plan
Local Education Authority	NOT Covered by the Plan
Ajphafeto Protein Testing	NOT Covered by the Plan
Long Term Care for month of entry plus one	Covered by the Plan
Long Term Care after month of entry plus one	NOT Covered by the Plan
Special AIDS drugs	NOT Covered by the Plan

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care
1. Average Cost Per Unit	$ 32.67	$ 126.04	$ 611.26	$ 13.79	$ 139.87
2. Units per Eligible	26.584	74.792	3.169	9.882	0.000
3. Addt'l Capitation Amts.	$ 2.96	$ 0.09	$ 9.89	$ 0.02	$ 0.00
Cost per Elig. per Mo.	$ 75.33	$ 785.66	$ 171.31	$ 11.38	$ 0.00
Adjustments					
a. Demographics	1.000	1.000	1.000	1.000	1.000
b. Area	1 043	1.000	1.000	1.000	1.000
c. Coverages	0.918	0.648	0.957	0.992	0.998
d. Interest	0.995	0.995	0.995	0.995	0.995
Adjusted Base Cost	$ 71.77	$ 506.56	$ 163.12	$ 11.23	$ 0.00
3. Legislative Adjs.	0.963	1.006	0.977	0.982	1.186
4. Trend Adjustments					
a. Cost per Unit	1.000	1.100	1.050	1.000	1.100
b. Units per Eligible	1.100	1.210	1.050	1.045	0.950
Projected Cost per Eligible	$ 76.03	$ 678.28	$ 175.70	$ 11.52	$ 0.00
5. Stop Loss Reins.		Amount	$ 0		Rate
6. CHDP					
7.Fee-for-Service Adj.					
Capitation Rate With FQHC Increment		$ 995.00 /Without		$ 995.00	

Rate Calculation	Other	FFSE	FQHC Increment	Total
1. Average Cost Per Unit	$ 42.30	$ 69.96	$ 0.00	
2. Units per Eligible	36.392	0.349	0.349	
3. Addt'l Capitation Amts.	$ 0.00	$ 0.00	$ 0.00	
Cost per Elig. per Mo.	$ 128.28	$ 2.04	$ 0.00	$ 1.174.00
Adjustments				
a. Demographics	1.000	1.000	1.000	
b. Area	1.000	1.000	1.000	
c. Coverages	0.599	0.951	0.951	
d. Interest	0.995	0.995	0.995	
Adjusted Base Cost	$ 76.46	$ 1.93	$ 0.00	$ 831.07
3. Legislative Adjs.	0.979	0.984	0.984	
4. Trend Adjustments				
a. Cost per Unit	1.100	1.000	1.000	
b. Units per Eligible	1.000	1.000	1.000	
Projected Cost per Eligible	$ 82.34	$ 1.90	$ 0.00	$ 1.025.77
5. Stop Loss Reins.	0.0%		Premium	0.00
6. CHDP				0.00
7.Fee-for-Service Adj.	3.0			(30.77)
Capitation Rate With FQHC Increment				

[LETTER HEAD OF DEPARTMENT OF HEALTH SERVICES]

June 1, 1999

John Molina, M.D.
Molina Medical Centers, Inc.
One Golden Shore
Long Beach, CA 90802

Dear Dr. Molina :

In accordance with Article III, Section 3.34.2 of your Contract, the enclosed Change Order authorizes the coverage of aid codes 7A, 47, and 72 and transmits Molina Medical Center, Inc., capitation rates for these aid codes for the period April 1, 1999, to September 30, 1999. The new rates will be effective April 1, 1999.

If you have any questions, please contact your contract manager.

Sincerely,

/s/

Susanne M. Hughes
Acting Chief
Medi-Cal Managed Care Division

Enclosures

[LETTER HEAD OF DEPARTMENT OF HEALTH SERVICES]

CHANGE ORDER NUMBER C2 to CONTRACT No. 95-23637 ADDING AID CODES 7A, 47, AND 72 AND CAPITATION RATES FOR THE PERIOD APRIL 1, 1999 TO SEPTEMBER 30, 1999, BY ADDING ADDITIONAL LANGUAGE TO ARTICLE II, SECTION Y, ELIGIBLE BENEFICIARY AND ARTICLE V, SECTIONS 5.3 CAPITATION RATES; AND 5.4 CAPITATION RATES CONSTITUTE PAYMENT IN FULL, Issued May 21, 1999.

1. Article II, Section Y, Eligible Beneficiary, following the words "Medically Indigent Adult - aid code 86", the following words are added "Percent of Poverty - aid codes 7A, 47, and 72."

All other terms, conditions, and provisions contained in Article II, Section Y remain unchanged.

2. 5.3 CAPITATION RATES

FOR THE PERIOD 04/01/99 - 09/30/99

GROUP	AID CODES	RATE
Percent of Poverty	7A	$ 54.11
Percent of Poverty	47/72	$ 60.05

In the future, DHS may be splitting existing aid codes into new aid codes. The new split aid codes will be in the same aid code group category as the original aid code. If DHS establishes new aid codes by splitting existing aid codes, Contractor agrees to accept Eligible Beneficiaries with these new aid codes as Members and to provide covered services to these Members at the monthly capitation rate specified for the original aid code group category. The Department shall confirm all aid code splits, and the rates of payment for such new aid codes, in writing to Contractor as soon as practicable after such aid code splits occur.

All other terms, conditions, and provisions contained in Section 5.3 remain unchanged.

3. 5.4 CAPITATION RATES CONSTITUTE PAYMENT IN FULL.

The actuarial basis for the determination of the capitation payment rates for Aid Codes 7A, 47, and 72 is outlined in Attachment 1 (consisting of 2 pages).

4. All other terms, conditions, and provisions contained in Section 5.4 remain unchanged.

Id Group Poverty - 7A | Base: Statewide Family Age Adjusted
Base Period: FY 96/97

Payments at End of Month

Services==>	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Nursing Facility	Other
1. Base Cost	$ 10.40	$ 6.74	$ 13.64	$ 3.91	$ 0.24	$ 8.30
2. Age/Sex Adjustments	1.000	1.000	1.000	1.000	1.000	1.000
3. Eligibility Adjustments	1.000	1.000	1.000	1.000	1.000	1.000
4. Coverage Adjustments	0.997	0.997	0.999	0.964	1.000	0.891
5. Interest Offset	0.995	1.001	0.991	0.993	0.998	0.995
Contract Cost FY 96/97	$ 10.32	$ 6.73	$ 13.50	$ 3.74	$ 0.24	$ 7.36
6. Legislative Adjustments	1.044	0.740	0.985	1.021	1.061	1.150
7. Trend Adjustments						
a. Cost per Unit	1.000	1.308	1.055	0.970	1.000	1.445
b. Utilization	1.000	1.027	1.050	1.000	1.107	1.000
Projeced Cost 10/98-9/99	$ 10.77	$ 6.69	$ 14.73	$ 3.70	$ 0.28	$ 12.23
8. CHDP						
9. Administrative Allowance					1.6%	
Fee-for-Service Equivalent Cost						
Fee-for-Service Adj.					94%	
Capitation Rate with FQHC increment						
Capitation Rate without FQHC increment						

Services==>	FFSE	FQHC Increment	Total
1. Base Cost	$ 2,98	$ 1.21	$ 47.42
2. Age/Sex Adjustments	1.000	1.000	
3. Eligibility Adjustments	1.000	1.000	
4. Coverage Adjustments	0.991	0.991	
5. Interest Offset	0.998	0.998	
Contract Cost FY 96/97	$ 2.94	$ 1.20	$ 46.03
6. Legislative Adjustments	1.024	1.024	
7. Trend Adjustments			
a. Cost per Unit	1.071	1.071	
b. utilization	1.265	1.265	
Projeced Cost 10/98-9/99	$ 4.08	$ 1.66	$ 54.14
8. CHDP			$ 2.54
9. Administrative Allowance			$ 0.88
Fee-for-Service Equivalent Cost			$ 57.56
Fee-for-Service Adj.			(3.45)
Capitation Rate with FQHC increment			$ 54.11
Capitation Rate without FQHC increment			$ 52.55

Id Group Poverty - 47/72

Base: Statewide
Base Period: FY 96/97

Payments at End of Month

Services ==>	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Nursing Facility	Other
1. Base Cost	$ 10.66	$ 7.27	$ 20.52	$ 5.31	$ 0.14	$ 2.92
2. Age/Sex Adjustments	1.000	1.000	1.000	1.000	1.000	1.000
3. Eligibility Adjustments	1.000	1.000	1.000	1.000	1.000	1.000
4. Coverage Adjustments	0.997	0.997	0.999	0.964	1.000	0.891
5. Interest Offset	0.995	1.001	0.991	0.993	0.998	0.995
Contract Cost FY 96/97	$ 10.57	$ 7.25	$ 20.32	$ 5.09	$ 0.14	$ 2.59
6. Legislative Adjustments	1.044	0.740	0.985	1.021	1.061	1.150
7. Trend Adjustments						
a. Cost per Unit	1.000	1.306	1.055	0.970	1.000	1.445
b. Utilization	1.000	1.027	1.050	1.000	1.107	1.000
Project Cost 10/98-9/99	$ 11.04	$ 7.21	$ 22.17	$ 5.04	$ 0.16	$ 4.30
8. CHDP						
9. Administrative Allowance					1.6%	
Fee-for-Service Equivalent Cost						
Fee-for-Service Adj.					94%	
Capitation Rate with FQHC increment						
Capitation Rate without FQHC increment						

Payments at End of Month

Services==>	FFSE	FQHC Increment	Total
1. Base Cost	$ 5.42	$ 2.21	$ 54.45
2. Age/Sex Adjustments	1.000	1.000	
3. Eligibility Adjustments	1.000	1.000	
4. Coverage Adjustments	0.991	0.991	
5. Interest Offset	0.998	0.998	
Contract Cost FY 96/97	$ 5.36	$ 2.18	$ 53.50
6. Legislative Adjustments	1024		
7. Trend Adjustments			
a. Cost per Unit	1.071	1.071	
b. Utilization	1.265	1.265	
Project Cost 10/98-9/99	$ 7.44	$ 3.02	$ 60.38
8. CHDP			$ 2.54
9. Administrative Allowance			$ 0.96
Fee-for-Service Equivalent Cost			$ 63.88
Fee-for-Service Adj.			(3.83)
Capitation Rate with FQHC increment			$ 60.05
Capitation Rate without FQHC increment			$ 57.21

[LETTER HEAD OF DEPARTMENT OF HEALTH SERVICES]

July 1, 1999

John Molina, M.D.
Molina Medical Centers, Inc.
One Golden Share
Long Beach, CA 90802

Dear Dr. Molina:

In accordance with Article III, Section 3.34.2 of your Contract, the enclosed Change Order authorizes the change in rates for FQHC and RHC subcontracts and transmits Molina Medical Centers, Inc. rates for the period July 1, 1999 through September 30, 1999. This Change Order also changes contract Sections 3.27.6, Federally Qualified Health Centers/Rural Health Clinics; 5.3 Capitation Rates; 5.4 Capitation Rates Constitute Payment in Full; 5.13 FQHC and RHC Risk Corridor Payments; 6.3.6 Submittal of FQHC and RHC payment information and 6.6.21 FQHC and RHC Contracts. The new rates will appear in your capitation rate beginning July 1, 1999.

If you have any questions, please contact your contract manager.

Sincerely,

/s/
Susanne M. Hughes
Acting Chief
Medi-Cal Managed Care Division

Enclosures

[LETTER HEAD OF DEPARTMENT OF HEALTH SERVICES]

CHANGE ORDER NUMBER C3 TO CONTRACT NO. 95-23637 BY CHANGING CONTRACT SECTIONS 3.27.6 FEDERALLY QUALIFIED HEALTH CENTERS/RURAL HEALTH CLINICS; 5.3 CAPITATION RATES; 5.4 CAPITATION RATES CONSTITUTE PAYMENT IN FULL; 5.13 FQHC/RHC RISK CORRIDOR PAYMENTS; 6.3.6 SUBMITTAL OF FQHC AND RHC PAYMENT INFORMATION AND 6.6.21 FQHC AND RURAL HEALTH CLINIC (RHC) CONTRACTS. Issued July 1,1999.

1. 3.27.6 FEDERALLY QUALIFIED HEALTH CENTERS/RURAL HEALTH CLINICS

A. Contractor shall not enter into a Subcontract with a Federally Qualified Health Center (FQHC) or a Rural Health Clinic (RHC) unless DHS approves the provisions regarding rates, which shall be subject to the standard that they be reasonable, as determined by DHS, in relation to the services to be provided, in accordance with Article VI, Section 6.6.21 FQHC and RHC Contracts. In Subcontracts where the FQHC or RHC has made the election to be reimbursed on a reasonable cost basis by the State, provisions shall be included that require the subcontractor to keep a record of the number of visits by plan Members separate from Fee-For-Service Medi-Cal beneficiaries, in addition to any other data reporting requirements of the Subcontract. The provisions of this section shall end June 30, 1999.

B. The provisions of this section shall apply beginning July 1, 1999. Contractor shall submit to DHS, within 30 days of a request and in the form and manner specified by DHS, for each of Contractor's FQHC and RHC Subcontracts the services provided and the reimbursement level and amount. Further, Contractor shall certify to DHS that pursuant to Welfare and Institutions Code, Section 14087.325(b) and (d), as amended by Chapter 894/Statutes of 1998, that FQHC and RHC Subcontract terms and conditions are the same as offered to other Subcontractors providing similar scope of service and that reimbursement is not less than the level and amount of payment that Contractor makes for the same scope of services furnished by a provider that is not a FQHC or RHC. Effective July 1, 1999, Contractor shall not be required to pay FQHCs and RHCs at the Medi-Cal interim per visit rate described in Section 6.6.22. Rather, Contractor shall be required to pay its FQHC and RHC Subcontractors reimbursement that is

not less than the level and amount of payment that Contractor makes for the same scope of services furnished by a provider that is not a FQHC or RHC. Effective July 1, 1999, Contractor capitation rates will be reduced to reflect the removal of the requirement to pay FQHCs and RHCs the Medi-Cal interim per visit rate. DHS reserves the right to review and audit Contractor's FQHC and RHC reimbursement at its discretion to ensure compliance with the state and federal law and shall approve all FQHC and RHC Subcontracts consistent with the provisions of Welfare and Institutions Code, Section 14087.325(h).

C. Subcontracts with FQHCs shall also meet Contract requirements of Article VI, Sections 6.6.20, FQHC services and 6.6.21, FQHC and Rural Health Clinic Subcontracts. Subcontracts with RHCs shall also meet Contract requirements of Article VI, Section 6.6.21

D. In Subcontracts where a negotiated reimbursement rate is agreed to as total payment, a provision that such rate constitutes total payment shall be included in the Subcontract.

2. 5.3 CAPITATION RATES

FOR THE PERIOD 7/1/99 - 9/30/99 RIVERSIDE COUNTY

GROUPS	AID CODES	RATE
Fami1y	01, 0A, 02, 08, 30, 32, 3G, 33, 3H, 34, 35, 38, 39, 3A, 3C, 3N, 3P, 3R, 3U, 3R, 40, 54, 59, 7X; CalWORKS: 3E, 3L, 3M	$ 78.41
Disabled	20, 24, 26, 28, 36, 60, 64, 66, 68, 6A, 6C, 6N, 6P, 6R	$ 222.61
Aged	10, 14, 16, 18	$ 160.47
Child	03, 04, 45, 4C, 4K, 5K, 82	$ 92.75
Adult	86	$ 705.26
AIDS Beneficiary		$ 962.42
Percent of Poverty	7A	$ 52.55
Percent of Poverty	47.72	$ 57.21

For the period 7/1/99 - 9/30/99 SAN BERNARDINO COUNTY

GROUPS	AID CODES	RATE
Family	01, 0A, 02, 08, 30, 32, 3G, 33, 3H, 34, 35, 38, 39, 3A, 3C, 3N, 3P, 3R, 3U, 40, 54, 59, 7X; Cal WORKS: 3E, 3L, 3M	$ 80.41
Disabled	20, 24, 26, 28, 36, 60, 64, 66, 68, 6A, 6C, 6N, 6P, 6R	$ 233.49
Aged	10, 14, 16, 18	$ 163.77
Child	03, 04, 45, 4C, 4K, 5K, 82	$ 106.35
Adult	86	$ 790.53
AIDS Beneficiary		$ 995.00
Percent of Poverty	7A	$ 52.55
Percent of Poverty	47,72	$ 57.21

3. 5.4 CAPITATION RATES CONSTITUTE PAYMENT IN FULL

The actuarial basis for the determination of the capitation payment rates is outlined in Attachment 1 (consisting of 16 pages).

All other terms, conditions, and provisions contained in Section 5.4 remain unchanged.

4. 5.13 FQHC/RHC RISK CORRIDOR PAYMENTS

For service periods beginning October 1, 1997 and through June 30, 1999 provided that Contractor has submitted expenditure data to DHS in the form and manner specified by DHS, DHS shall perform reconciliations to determine the variance between the contractor's actual FQHC/RHC expenses and the amount they were paid through capitation rates for FQHC/RHC services.

For each annual reconciliation, if, pursuant to subcontracts with FQHCs and RHCs that have been reviewed and approved in writing by DHS, Contractor has paid subcontracting FQHCs and RHCs in the aggregate interim rate payments an amount greater than 110 percent of the dollar value of FQHC and RHC interim rate payments included in Contractor's capitation rates, DHS shall pay Contractor the amount in excess of 110 percent.

For each annual reconciliation, if, pursuant to subcontracts with FQHCs and RHCs that have been reviewed and approved in writing by DHS, Contractor has paid subcontracting FQHCs and RHCs in the aggregate an amount less than 90 percent of the dollar value of FQHC and RHC interim rate payments included in Contractor's capitation rates,

Contractor shall refund the amount below 90 percent to DHS. DHS may recover amounts owed by Contractor pursuant to this section through an offset to the capitation payments made to Contractor, pursuant to Section 5.11(C), Recovery of Capitation Payments.

All reconciliations shall be subject to an annual reconciliation audit at which time payments to or recoupments from Contractor shall be finalized.

5. 6.3.6 SUBMITTAL OF FQHC AND RHC PAYMENT INFORMATION

Effective with the October 1997 month of service, Contractor shall keep a record of the number of visits by plan Members to each FQHC and RHC contracting with Contractor and related payment information, and shall submit this information to DHS in the frequency, format, and manner specified by DHS. This requirement shall remain in effect for service periods through the June 30, 1999.

6. 6.6.21 FQHC AND RURAL HEALTH CLINIC (RHC) CONTRACTS

A. This requirement shall remain in effect for service periods through June 30, 1999. Notwithstanding Article III, Section 3.26.4, Departmental Approval - Federally Qualified HMOs, Contractor shall not enter into any contract with an FQHC or RHC for provision of Covered Services to Members without prior approval by DHS. All contracts with FQHCs or RHCs shall provide reimbursement to the FQHC or RHC on the basis of each center's or clinic's Medi-Cal interim per visit rate, applicable on the date the reimbursable services were provided, as established by DHS, unless:

   1. DHS has approved in writing an alternate reimbursement methodology; or

   2. The FQHC or RHC agrees to be reimbursed on an at-risk basis and such agreement is contained in the contract with the center or clinic. In contracts where the negotiated rate is agreed to as total payment, the contract shall state that such payment constitutes total payment to the entity.

B. To the extent that Indian Health Service facilities qualify as FQHCs or RHCs, the same reimbursement requirements shall apply to contracts with Indian Health Service facilities.

7. All other terms, conditions, and provisions contained in Section 5.4 remain unchanged.

Plan Name:	Molina Medical Center	Plan #: 355	Date: 04-May-99
County:	Riverside	Plan Type: Commercial Plan	Base Period: FY 96/97
Aid Code Grouping:	Family		

The Rate Period is October 1, 1998 to September 30,1999

Capitation Payments at the Beginning of the Month

C3 to Contract 95-23637
Attachment 1

Coverages	
CCS Indicated Claims	NOT Covered by the Plan
Mental Health Outpatient Services	NOT Covered by the Plan
Mental Health Pharmacy Costs	NOT Covered by the Plan
Mental Health Hospital Inpatient Services	NOT Covered by the Plan
Eyewear	NOT Covered by the Plan
Heroin Detoxification	NOT Covered by the Plan
AIDS Waiver Services	NOT Covered by the Plan
Adult Day Health Care	NOT Covered by the Plan
Chiropractor/Acupuncture	NOT Covered by the Plan
Local Education Authority	NOT Covered by the Plan
Alphafeto Protein Testing	NOT Covered by the Plan
Long Term Care for month of entry plus one	Covered by the Plan
Long Term Care after month of entry plus one	NOT Covered by the Plan
Special AIDS drugs	NOT Covered by the Plan

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other
1. Average Cost Per Unit	$ 69.46	$ 19.88	$ 864.71	$ 16.16	$ 812.04	$ 20.09
2. Units per Eligible	4.014	4.683	0.373	2.146	0.004	3.532
3. Addt'l Capitation Amts.	$ 0.37	$ 0.05	$ 4.62	$ 0.01	$ 0.00	$ 0.00
Cost per Elig. per Mo.	$ 23.60	$ 7.81	$ 31.50	$ 2.90	$ 0.27	$ 5.91
Adjustments						
a. Demographics	1.004	0.976	1.023	1.002	1.000	0.985
b. Area	1.043	1.000	1.000	1.000	1.000	1.000
c. Coverages	0.975	0.992	0.968	0.956	0.995	0.833
d. Interest	0.995	0.995	0.995	0.995	0.995	0.995
Adjusted Base Cost	$ 23.97	$ 7.52	$ 31.04	$ 2.76	$ 0.27	$ 4.82
3. Legislative Adjs.	1.053	1.053	0.998	1.023	1.141	1.046
4. Trend Adjustments						
a. Cost per Unit	1.000	1.100	1.050	1.000	1.000	0.950
b. Units per Eligible	0.950	1.000	1.050	0.950	1.050	1.050
Projected Cost per Eligible	$ 23.98	$ 8.71	$ 34.15	$ 2.68	$ 0.32	$ 5.03
5. Stop Loss Reins.	Amount		$ 0	Rate		0.0%
6. CHDP						
7. Fee-for-Service Adj.						-3.0%
Capitation Rate with FQHC Increment		$ 78.73 / Without		$ 78.41		

Rate Calculation	FQHC FFSE	Increment	Total
1. Average Cost Per Unit	$ 68.39	$ 24.41	
2. Units per Eligible	0.168	0.168	
3. Addt'l Capitation Amts.	$ 0.00	$ 0.00	
Cost per Elig. per Mo.	$ 0.96	$ 0.34	$ 73.29
Adjustments			
a. Demographics	0.994	0.994	
b. Area	1.000	1.000	
c. Coverages	0.935	0.935	
d. Interest	0.995	0.995	
Adjusted Base Cost	$ 0.89	$ 0.31	$ 71.58
3. Legislative Adjs.	1.027	1.027	
4. Trend Adjustments			
a. Cost per Unit	1.000	1.000	
b. Units per Eligible	1.000	1.000	
Projected Cost per Eligible	$ 0.91	$ 0.32	$ 76.10
5. Stop Loss Reins	Premium		0.00
6. CHDP			5.06
7. Fee-for-Service Adj.			(2.43)
Capitation Rate with FQHC Increment			

Plan Name:	Molina Medical Center	Plan #:	355	Date:	04-May-99	C3 to Contract
County:	Riverside	Plan Type:	Commercial Plan	Base Period:	FY 96/97	95-23637
Aid Code Grouping:	Aged					Attachment 1

The Rate Period is October 1, 1998 to September 30, 1999   Capitation Payments at the Beginning of the Month

Coverages

Coverage	Status
CCS Indicated Claims	NOT Covered by the Plan
Mental Health Outpatient Services	NOT Covered by the Plan
Mental Health Pharmacy Costs	NOT Covered by the Plan
Mental Health Hospital Inpatient Services	NOT Covered by the Plan
Eyewear	NOT Covered by the Plan
Heroin Detoxification	NOT Covered by the Plan
AIDS Waiver Services	NOT Covered by the Plan
Adult Day Health Care	NOT Covered by the Plan
Chiropractor/Acupuncture	NOT Covered by the Plan
Local Education Authority	NOT Covered by the Plan
Alphafeto Protein Testing	NOT Covered by the Plan
Long Term Care for month of entry plus one	Covered by the Plan
Long Term Care after month of entry plus one	NOT Covered by the Plan
Special AIDS drugs	NOT Covered by the Plan

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other
1. Average Cost Per Unit	$ 48.90	$ 32.71	$ 287.24	$ 10.02	$ 77.33	$ 6.41
2. Units per Eligible	4.472	21.914	1.265	3.306	2.016	12.862
3. Addt'l Capitation Amts.	$ 1.29	$ 0.00	$ 7.41	$ 0.02	$ 0.00	$ 0.00
Cost per Ellg. per Mo.	$ 19.51	$ 59.73	$ 37.69	$ 2.78	$ 12.99	$ 6.87
Adjustments						
a. Demographics	0.955	1.019	0.957	0.970	1.039	1.025
b. Area	1.043	1.000	1.000	1.000	1.000	1.000
c. Coverages	0.981	0.996	0.997	0.986	0.997	0.791
d. Interest	0.995	0.995	0.995	0.995	0.995	0.995
Adjusted Base Cost	$ 18.97	$ 60.32	$ 35.78	$ 2.65	$ 13.39	$ 5.54
3. Legislative Adjs.	0.939	1.049	0.926	0.931	1.140	0.927
4. Trend Adjustments						
a. Cost per Unit	1.100	1.100	1.100	1.050	1.000	1.050
b. Units per Eligible	1.100	1.155	1.100	1.100	1.000	0.950
Projected Cost per Eligible	$ 21.55	$ 80.39	$ 40.09	$ 2.85	$ 15.26	$ 5.12
5. Stop Loss Reins.	Amount		$ 0		Rate	0.0%
6. CHDP						
7. Fee-for-Service Adj.						-3.0%
Capitation Rate With FQHC Increment		$ 160.47 / Without		$ 160.47		

Rate Calculation	FFSE	FQHC Increment	Total
1. Average Cost Per Unit	$ 28.59	$ 0.00	
2. Units per Eligible	0.132	0.132	
3. Addt'l Capitation Amts.	$ 0.00	$ 0.00	
Cost per Elig. per Mo.	$ 0.31	$ 0.00	$ 139.88
Adjustments			
a. Demographics	0.970	0.970	
b. Area	1.000	1.000	
c. Coverages	0.603	0.603	
d. Interest	0.995	0.995	
Adjusted Base Cost	$ 0.18	$ 0.00	$ 136.83
3. Legislative Adjs.	0.926	0.926	
4. Trend Adjustments			
a. Cost per Unit	1.000	1.000	
b. Units per Eligible	1.000	1.000	
Projected Cost per Eligible	$ 0.17	$ 0.00	$ 165.43
5. Stop Loss Reins.	Premium		0.00
6. CHDP			0.00
7. Fee-for-Service Adj.			(4.96)
Capitation Rate With FQHC Increment			

Plan Name:	Molina Medical Center	Plan #: 355	Date:	04-May-99	C3 to Contract
County:	Riverside	Plan Type: Commercial Plan	Base Period:	FY 96/97	95-23637
Aid Code Grouping:	Disabled				Attachment 1

The Rate Period is October 1, 1998 to September 30, 1999   Capitation Payments at the Beginning of the Month

Coverages

CCS Indicated Claims	NOT Covered by the Plan
Mental Health Outpatient Services	NOT Covered by the Plan
Mental Health Pharmacy Costs	NOT Covered by the Plan
Mental Health Hospital Inpatient Services	NOT Covered by the Plan
Eyewear	NOT Covered by the Plan
Heroin Detoxification	NOT Covered by the Plan
AIDS Waiver Services	NOT Covered by the Plan
Adult Day Health Care	NOT Covered by the Plan
Chiropractor/Acupuncture	NOT Covered by the Plan
Local Education Authority	NOT Covered by the Plan
Alphafeto Protein Testing	NOT Covered by the Plan
Long Term Care for month of entry plus one	Covered by the Plan
Long Term Care after month of entry plus one	NOT Covered by the Plan
Special AIDS drugs	NOT Covered by the Plan

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other
1. Average Cost Per Unit	$ 46.41	$ 39.70	$ 485.15	$ 12.37	$ 139.87	$ 10.16
2. Units per Eligible	6.873	26.861	1.556	5.050	0.459	21.959
3. Addt'l Capitation Amts.	$ 2.96	$ 0.09	$ 9.89	$ 0.02	$ 0.00	$ 0.00
Cost per Elig. per Mo.	$ 29.54	$ 88.96	$ 72.80	$ 5.23	$ 5.35	$ 18.59
Adjustments						
a. Demographics	0.983	0.989	0.981	0.998	1 000	1.015
b. Area	1.043	1.000	1.000	1.000	1.000	1.000
c. Coverages	0.900	0.875	0.920	0.973	0.995	0.878
d. Interest	0.995	0.995	0.995	0.995	0.995	0.995
Adjusted Base Cost	$ 27.12	$ 76.60	$ 65.37	$ 5.05	$ 5.30	$ 16.48
3. Legislative Adjs.	0.941	1.043	0.919	0.931	1.130	0.923
4. Trend Adjustments						
a. Cost per Unit	1.000	1.100	1.050	1.000	1.100	1.100
b. Units per Eligible	1.100	1.210	1.050	1.045	0.950	1.000
Projected Cost per Eligible	$ 28.07	$ 106.34	$ 66.23	$ 4.91	$ 6.26	$ 16.73
5. Stop Loss Reins.		Amount	$ 0		Rate	0.0%
6. CHDP						
7. Fee-for-Service Adj.						-3.0%
Capitation Rate With FQHC Increment		$ 222.61 / Without		$ 222.61		

Rate Calculation	FFSE	FQHC Increment	Total
1. Average Cost Per Unit	$ 66.52	$ 0.00	
2. Units per Eligible	0.216	0.216	
3. Addt'l Capitation Amts.	$ 0.00	$ 0.00	
Cost per Elig. per Mo.	$ 1.20	$ 0.00	$ 221.67
Adjustments			
a. Demographics	0.987	0.987	
b. Area	1.000	1.000	
c. Coverages	0.863	0.863	
d. Interest	0.995	0.995	
Adjusted Base Cost	$ 1.02	$ 0.00	$ 196.94
3. Legislative Adjs.	0.932	0.932	
4. Trend Adjustments			
a. Cost per Unit	1.000	1.000	
b. Units per Eligible	1.000	1.000	
Projected Cost per Eligible	$ 0.95	$ 0.00	$ 229.49
5. Stop Loss Reins.	Premium		0.00
6. CHDP			0.00
7. Fee-for-Service Adj.			(6.88)
Capitation Rate With FQHC Increment			

Plan Name:	Molina Medical Center	Plan #: 355	Date:	04-May-99	C3 to Contract
County:	Riverside	Plan Type: Commercial Plan	Base Period:	FY 96/97	95-23637
Aid Code Grouping:	Child				Attachment 1

The Rate Period is October 1, 1998 to September 30, 1999 Capitation Payments at the Beginning of the Month

Coverages

Coverage	Status
CCS Indicated Claims	NOT Covered by the Plan
Mental Health Oulpatient Services	NOT Covered by the Plan
Mental Health Pharmacy Costs	NOT Covered by the Plan
Mental Health Hospital Inpatient Services	NOT Covered by the Plan
Eyewear	NOT Covered by the Plan
Heroin Detoxification	NOT Covered by the Plan
AIDS Waiver Services	NOT Covered by the Plan
Adult Day Health Care	NOT Covered by the Plan
Chiropractor/Acupuncture	NOT Covered by the Plan
Local Education Authority	NOT Covered by the Plan
Alphafeto Protein Testing	MOT Covered by the Plan
Long Term Care for month of entry plus one	Covered by the Plan
Long Term Care after month of entry plus one	NOT Covered by the Plan
Special AIDS drugs	NOT Covered by the Plan

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other
1. Average Cost Per Unit	$ 67.42	$ 13.64	$ 889.41	$ 16.21	$ 469.38	$ 20.69
2. Units per Eligible	3.999	3.411	0.465	1.516	0.007	1.958
3. Addt'l Capitation Amts.	$ 0.23	$ 0.03	$ 2.90	$ 0.00	$ 0.00	$ 0.00
Cost per Elig. per Mo.	$ 22.70	$ 3.91	$ 37.36	$ 2.05	$ 0.27	$ 3.38
Adjustments						
a. Demographics	1.181	1.019	1.321	1.114	1.000	1.165
b. Area	1.043	1.000	1.000	1.000	1.000	1.000
c. Coverages	0.974	0.984	0.952	0.973	0.996	0.815
d. Interest	0.995	0.995	0.995	0.995	0.995	0.995
Adjusted Base Cost	$ 27.10	$ 3.90	$ 46.75	$ 2.21	$ 0.27	$ 3.19
3. Legislative Adjs.	1.076	1.047	0.999	1.024	1.134	1.090
4. Trend Adjustments						
a. Cost per Unit	1 000	1.100	1.050	1.000	1.000	0.950
b. Units per Eligible	0.950	1.000	1.050	0.950	1.050	1.050
Projected Cost per Eligible	$ 27.70	$ 4.49	$ 51.49	$ 2.15	$ 0.32	$ 3.47
5. Stop Loss Reins.		Amount	$ 0		Rate	0.0%
6. CHDP						
7. Fee-for-Service Adj.						-3.0%
Capitation Rate With FQHC Increment		$93.09 / Without		$ 92.75		

Rate Calculation	FFSE	FQHC Increment	Total
1. Average Cost Per Unit	$ 68.39	$ 24.41	
2. Units per Eligible	0.168	0.168	
3. Addt'l Capitation Amts.	$ 0.00	$ 0.00	
Cost per Etlg. per Mo.	$ 0.96	$ 0.34	$ 70.97
Adjustments			
a. Demographics	1.003	1.003	
b. Area	1.000	1.000	
c. Coverages	0.970	0.970	
d. Interest	0.995	0.995	
Adjusted Base Cost	$ 0.93	$ 0.33	$ 84.68
3. Legislative Adjs.	1.031	1.031	
4. Trend Adjustments			
a. Cost per Unit	1.000	1.000	
b. Units per Eligible	1.000	1.000	
Projected Cost per Eligible	$ 0.96	$ 0.34	$ 90.92
5. Stop Loss Reins.		Premium	0.00
6. CHDP			5.04
7. Fee-for-Service Adj.			(2.87)
Capitation Rate With FQHC Increment			

The Rate Period is October 1, 1998 to September 30, 1999 Capitation Payments at the Beginning of the Month

Coverages

CCS Indicated Claims	NOT Covered by the Plan
Mental Health Oulpatient Services	NOT Covered by the Plan
Mental Health Pharmacy Costs	NOT Covered by the Plan
Mental Health Hospital Inpatient Services	NOT Covered by the Plan
Eyewear	NOT Covered by the Plan
Heroin Detoxification	NOT Covered by the Plan
AIDS Waiver Services	NOT Covered by the Plan
Adult Day Health Care	NOT Covered by the Plan
Chiropractor/Acupuncture	NOT Covered by the Plan
Local Education Authority	NOT Covered by the Plan
Alphafeto Protein Testing	NOT Covered by the Plan
Long Term Care for month of entry plus one	Covered by the Plan
Long Term Care after month of entry plus one	NOT Covered by the Plan
Special AIDS drugs	NOT Covered by the Plan

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Oulpatient	Long Term Care	Other
1. Average Cost Per Unit	$ 90.48	$ 17.11	$ 964.66	$ 15.76	$ 812.04	$ 36.13
2. Units per Eligible	21.383	5.818	5.446	4.679	0.000	10.172
3. Addt'l Capitation Amts.	$ 0.37	$ 0.06	$ 35.62	$ 0.08	$ 0.00	$ 0.00
Cost per Elig. per Mo.	$ 161.60	$ 8.36	$ 473.41	$ 6.23	$ 0.00	$ 30.63
Adjustments						
a. Demographics	1.000	1.000	1.000	1.000	1.000	1 000
b. Area	1.043	1.000	1.000	1.000	1 000	1.000
c. Coverages	0.999	0.999	0.999	0.989	1.000	0.809
d. Interest	0.995	0.995	0.995	0.995	0.995	0.995
Adjusted Base Cost	$ 167.54	$ 8.31	$ 470.57	$ 6.13	$ 0.00	$ 24.66
3. Legislative Adjs.	1.029	1.054	1.000	1.022	1.102	1.004
4. Trend Adjustments						
a. Cost per Unit	1.000	1.100	1.050	1.000	1.000	0.950
b. Units per Eligible	0.950	1.000	1.050	0.950	1.050	1.050
Projected Cost per Eligible	$ 163.78	$ 9.63	$ 518.80	$ 5.95	$ 0.00	$ 24.70
5. Stop Loss Reins.	Amount		$ 0	Rate		0.0%
6. CHDP						
7. Fee-for-Service Adj.						-3.0%
Capitation Rate With FQHC Increment		$ 706.77 / Without		$ 705.26		

Rate Calculation	FFSE	FQHC Increment	Total
1. Average Cost Per Unit	$ 68.39	$ 24.41	
2. Units per Eligible	0.735	0.735	
3. Addt'l Capitation Amts.	$ 0.00	$ 0.00	
Cost per Elig. per Mo.	$ 4.19	$ 1.50	$ 685.92
Adjustments			
a. Demographics	1.000	1.000	
b. Area	1.000	1.000	
c. Coverages	0.995	0.995	
d. Interest	0.995	0.995	
Adjusted Base Cost	$ 4.15	$ 1.49	$ 682.85
3. Legislative Adjs.	1.015	1.015	
4. Trend Adjustments			
a. Cost per Unit	1.000	1.000	
b. Units per Eligible	1.000	1.000	
Projected Cost per Eligible	$ 4.21	$ 1.51	$ 728.58
5. Stop Loss Reins.		Premium	0.00
6. CHDP			0.00
7. Fee-for-Service Adj.			(21.81)
Capitation Rate With FQHC Increment			

Plan Name:	Molina Medical Center	Plan #: 355	Date:	04-May-99	C3 to Contract
County:	Riverside	Plan Type: Commercial Plan	Base Period:	FY 96/97	95-23637
Aid Code Grouping:	AIDS				Attachment 1

The Rate Period is October 1, 1998 to September 30, 1999   Capitation Payments at the Beginning of the Month

Coverages

Coverage	Status
CCS Indicated Claims	NOT Covered by the Plan
Mental Health Outpatient Services	NOT Covered by the Plan
Mental Health Pharmacy Costs	NOT Covered by the Plan
Mental Health Hospital Inpaitient Services	NOT Covered by the Plan
Eyewear	NOT Covered by the Plan
Heroin Detoxification	NOT Covered by the Plan
AIDS Waiver Services	NOT Covered by the Plan
Adult Day Health Care	NOT Covered by the Plan
Chiropractor/Acupuncture	NOT Covered by the Plan
Local Education Authority	NOT Covered by the Plan
Alphafeto Protein Testing	NOT Covered by the Plan
Long Term Care for month of entry plus one	Covered by the Plan
Long Term Care after month of entry plus one	NOT Covered by the Plan
Special AIDS drugs	NOT Covered by the Plan

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other
1. Average Cost Per Unit	$ 32.67	$ 126.04	$ 485.15	$ 13.79	$ 139.87	$ 42.30
2. Units per Eligible	26.305	74.792	3.169	9.882	0.000	36.392
3. Addt'l Capitation Arms.	$ 2.96	$ 0.09	$ 9.89	$ 0.02	$ 0.00	$ 0.00
Cost per Elig. per Mo.	$ 74.57	$ 785.66	$ 138.01	$ 11.38	$ 0.00	$ 128.28
Adjustments						
a. Demographics	1.000	1.000	1.000	1.000	1.000	1.000
b. Area	1 043	1.000	1.000	1.000	1.000	1.000
c. Coverages	0.918	0.648	0.957	0.992	0.998	0.599
d. Interest	0.995	0.995	0.995	0.995	0.995	0.995
Adjusted Base Cost	$ 71.04	$ 506.56	$ 131.42	$ 11.23	$ 0.00	$ 76.46
3. Legislative Adjs.	0.963	1.006	0.977	0.982	1.186	0.979
4. Trend Adjustments						
a. Cost par Unit	1.000	1.100	1.050	1.000	1.100	1.100
b. Units per Eligible	1.100	1.210	1.050	1.045	0.950	1.000
Projected Cost per Eligible	$ 75.25	$ 678.28	$ 141.56	$ 11.52	$ 0.00	$ 82.34
5. Stop Loss Reins.	Amount		$ 0		Rate	0.0%
6. CHDP						
7. Fee-for-Service Adj.						-3.0%
Capitation Rate With FQHC Increment		$ 962.42 / Without		$ 962.42		

Rule Calculation	FFSE	FQHC Increment	Total
1. Average Cost Per Unit	$ 66.52	$ 0.00	
2. Units per Eligible	0.628	0.628	
3. Addt'l Capitation Arms.	$ 0.00	$ 0.00	
Cost per Elig. per Mo.	$ 3.48	$ 0.00	$ 1.141.38
Adjustments			
a. Demographics	1.000	1.000	
b. Area	1.000	1.000	
c. Coverages	0.951	0.951	
d. Interest	0.995	0.995	
Adjusted Base Cost	$ 3.29	$ 0.00	$ 800.00
3. Legislative Adjs.	0.984	0.984	
4. Trend Adjustments			
a. Cost per Unit	1.000	1.000	
b. Units per Eligible	1.000	1.000	
Projected Cost per Eligible	$ 3.24	$ 0.00	$ 992.19
5. Stop Loss Reins.		Premium	0.00
6. CHDP			0.00
7. Fee-for-Service Adj.			
Capitation Rate With FQHC Increment			29.77

Aid Group Poverty - 7A   Base: Statewide Family Age Adjusted
Base Period : FY 96/97

Payments at End of Month

Services ==>	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Nursing Facility	Other	FFSE	FQHC Increment	Total
1. Base Cost	$ 10.40	$ 6.74	$ 13.64	$ 3.91	$ 0.24	$ 8.30	$ 2.98	$ 1.21	$47.42
2. Age/Sex Adjustments	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	
3. Eligibility Adjustments	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	
4. Coverage Adjustments	0.997	0.997	0.999	0.964	1.000	0.891	0.991	0.991	
5. Interest Offset	0.995	1.001	0.991	0.993	0.998	0.995	0.998	0.998	
Contract Cost FY 96/97	$ 10.32	$ 6.73	$ 13.50	$ 3.74	$ 0.24	$ 7.36	$ 2.94	$ 1.20	$46.03
6. Legislative Adjustments	1.044	0.740	0.985	1.021	1.061	1.150	1.024	1.024	
7. Trend Adjustments									
a. Cost per Unit	1.000	1.308	1.055	0.970	1.000	1.445	1.071	1.071	
b. Utilization	1.000	1.027	1.050	1.000	1.107	1.000	1.265	1.265	
Projected Cost 10/98-9/99	$ 10.77	$ 6.69	$ 14.73	$ 3.70	$ 0.28	$ 12.23	$ 4.08	$ 1.66	$54.14
8. CHDP									$ 2.54
9. Adiminiistrative Allowance						1.5%			$ 0.88
Fee-for-Service Equivalent Cost									$57.56
Fee-for-Services Adj.						94%			(3.45)
Capitation Rate with FQHC increment									$54.11
Capitation Rate without FQHC increment									$52.55

Aid Group Poverty - 47/72

Base: Statewide
Base Period: FY 96/97

Payments at End of Month

Services ==>	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Nursing Facility	Other	FFSE	FQHC Increment	Totals
1. Base Cost	$ 10.66	$ 7.27	$ 20.52	$ 5.31	$ 0.14	$ 2.92	$ 5.42	$ 2.21	$ 54.45
2. Age/Sex Adjustments	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	
3. Eligibility Adjustments	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	
4. Coverage Adjustments	0.997	0.997	0.999	0.964	1.000	0.891	0.991	0.991	
5. Interest Offset	0.995	1.001	0.991	0.993	0.998	0.995	0.998	0.998	
Contract Cost FY 96/97	$ 10.57	$ 7.25	$ 20.32	$ 5.09	$ 0.14	$ 2.59	$ 5.36	$ 2.18	$ 53.50
6. Legislative Adjustments	1.044	0.740	0.985	1.021	1.061	1.150	1.024	1.024	
7. Trend Adjustments									
a. Cost per Unit	1.000	1.308	1.055	0.970	1.000	1.445	1.071	1.071	
b. Utilization	1.000	1.027	1.050	1.000	1.107	1.000	1.265	1.265	
Projected Cost 10/98-9/99	$ 11.04	$ 7.21	$ 22.17	$ 5.04	$ 0.16	$ 4.30	$ 7.44	$ 3.02	$ 60.38
8. CHDP									$ 2.54
9. Administrative Allowance						1.6%			$ 0.96
Fee-for-Service Equivalent Cost									$ 63.88
Fee-for-Service Adj.						94%			(3.83)
Capitation Rate with FQHC increment									$ 60.05
Capitation Rate without FQHC increment									$ 57.21

The Rate Period is October 1, 1998 to September 30, 1999 Capitation Payments at the Beginning of the Month

Coverages

CCS Indicated Claims	NOT Covered by the Plan
Mental Health Outpatient Services	NOT Covered by the Plan
Mental Health Pharmacy Costs	NOT Covered by the Plan
Mental Health Hospital Inpatient Services	NOT Covered by the Plun
Eyewear	NOT Covered by the Plan
Heroin Detoxification	NOT Covered by the Plan
AIDS Waiver Services	NOT Covered by the Plan
Adult Day Health Care	NOT Covered by the Plan
Chiropractor/Acupuncture	NOT Covered by the Plan
Local Education Authority	NOT Covered by the Plan
Alphafelo Protein Testing	NOT Covered by the Plan
Long Term Care for month of entry plus one	Covered by the Plan
Long Term Care alter month of entry plus one	NOT Covered by the Plan
Special AIDS drugs	NOT Covered by the Plan

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other
1. Average Cost Per Unit	$ 69.46	$ 19.88	$ 978.02	$ 16.16	$ 812.04	$ 20.09
2. Units per Eligible	4.050	4.683	0.373	2.146	0.004	3.532
3. Addt'l Capitation Amts.	$ 0.37	$ 0.05	$ 4.62	$ 0.01	$ 0.00	$ 0.00
Cost per Elig. per Mo.	$ 23.81	$ 7.81	$ 35.02	$ 2.90	$ 0.27	$ 5.91
Adjustments						
a. Demographics	0.997	0.993	0.977	0.987	1.000	0.985
b. Area	1.043	1.000	1.000	1.000	1.000	1.000
c. Coverages	0.975	0.992	0.968	0.956	0.995	0.833
d. Interest	0.995	0.995	0.995	0.995	0.995	0.995
Adjusted Base Cost	$ 24.02	$ 7.65	$ 32.95	$ 2.72	$ 0.27	$ 4.82
3. Legislative Adjs.	1.053	1.053	0.998	1.023	1.141	1.046
4. Trend Adjustments						
a. Cost per Unit	1.000	1.100	1.050	1.000	1.000	0.950
b. Units per Eligible	0.950	1.000	1.050	0.950	1.050	1.050
Projected Cost per Eligible	$ 24.03	$ 8.86	$ 36.25	$ 2.64	$ 0.32	$ 5.03
5. Stop Loss Reins.	Amount		$ 0		Rate	0.0%
6. CHDP						
7. Fee-for-Service Adj.						-3.0%
Capitation Rate With FQHC Increment		$ 80.48 / Without		$ 80.41		

Rate Calculation	FFSE	FQHC Increment	Total
1. Average Cost Per Unit	$ 68.10	$ 7.33	
2. Units per Eligible	0.132	0.132	
3. Addt'l Capitation Amts.	$ 0.00	$ 0.00	
Cost per Elig. per Mo.	$ 0.75	$ 0.08	$ 76.55
Adjustments			
a. Demographics	0.992	0.992	
b. Area	1.000	1.000	
c. Coverages	0.935	0.935	
d. Interest	0.995	0.995	
Adjusted Base Cost	$ 0.69	$ 0.07	$ 73.19
3. Legislative Adj.	1.027	1.027	
4. Trend Adjustments			
a. Cost per Unit	1.000	1.000	
b. Units per Eligible	1.000	1.000	
Projected Cost per Eligible	$ 0.71	$ 0.07	$ 77.91
5. Stop Loss Reins.	Premium		0.00
6. CHDP			5.06
7. Fee-for-Service Adj.			(2.49)
Capitation Rate With FQHC Increment			

The Rate Period is October 1, 1998 to September 30, 1999   Capitation Payments at the Beginning of the Month

Coverages

Coverage	Status
CCS Indicated Claims	NOT Covered by the Plan
Mental Health Outpatient Services	NOT Covered by the Plan
Mental Health Pharmacy Costs	NOT Covered by the Plan
Mental Health Hospital Inpatient Services	NOT Covered by the Plan
Eyewear	NOT Covered by the Plan
Heroin Detoxification	NOT Covered by the Plan
AIDS Waiver Services	NOT Covered by the Plan
Adult Day Health Care	NOT Covered by the Plan
Chiropractor/Acupuncture	NOT Covered by the Plan
Local Education Authority	NOT Covered by the Plan
Alphafelo Protein Testing	NOT Covered by the Plan
Long Term Care for month of entry plus one	Covered by the Plan
Long Term Care after month of entry plus one	NOT Covered by the Plan
Special AIDS drugs	NOT Covered by the Plan

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other
1. Average Cost Per Unit	$ 46.41	$ 39.70	$ 611.26	$ 12.37	$ 139.87	$ 10.16
2. Units per Eligible	6.969	26.861	1.556	5.050	0.459	21.959
3. Addt'l Capitation Amts.	$ 2.96	$ 0.09	$ 9.89	$ 0.02	$ 0.00	$ 0.00
Cost per Elig. per Mo.	$ 29.91	$ 88.96	$ 89.15	$ 5.23	$ 5.35	$ 18.59
Adjustments						
a. Demographics	0.980	0.973	0.961	0.998	0.996	1.006
b. Area	1.043	1.000	1.000	1.000	1.000	1.000
c. Coverages	0.900	0.875	0.920	0.973	0.995	0.878
d. Interest	0.995	0.995	0.995	0.995	0.995	0.995
Adjusted Base Cost	$ 27.38	$ 75.36	$ 78.43	$ 5.05	$ 5.28	$ 16.34
3. Legislative Adjs.	0.941	1.043	0.919	0.931	1.130	0.923
4. Trend Adjustments						
a. Cost per Unit	1.000	1.100	1.050	1.000	1.100	1.100
b. Units per Eligible	1.100	1.210	1.050	1.045	0.950	1.000
Projected Cost per Eligible	$ 28.34	$ 104.62	$ 79.47	$ 4.91	$ 6.23	$ 16.59
5. Stop Loss Reins.	Amount		$ 0	Rate		0.0%
6. CHDP						
7. Fee-for-Service Adj.						-3.0%
Capitation Rate With FQHC Increment		$ 233.49 / Without		$ 233.49		

Rate Calculation	FFSE	FQHC Increment	Total
1. Average Cost Per Unit	$ 69.96	$ 0.00	
2. Units per Eligible	0.120	0.120	
3. Addt'l Capitation Amts.	$ 0.00	$ 0.00	
Cost per Elig. per Mo.	$ 0.70	$ 0.00	$ 237.89
Adjustments			
a. Demographics	0.989	0.989	
b. Area	1.000	1.000	
c. Coverages	0.863	0.863	
d. Interest	0.995	0.995	
Adjusted Base Cost	$ 0.59	$ 0.00	$ 208.43
3. Legislative Adjs.	0.932	0.932	
4. Trend Adjustments			
a. Cost per Unit	1.000	1.000	
b. Units per Eligible	1.000	1.000	
Projected Cost per Eligible	$ 0.55	$ 0.00	$ 240.71
5. Stop Loss Reins.	Premium		0.00
6. CHDP			0.00
7. Fee-for-Service Adj.			(7.22)
Capitation Rate With FQHC Increment			

Plan Name:	Molina Medical Center	Plan #:	356	Date:	04-May-99
County:	San Bernardino	Plan Type:	Commercial Plan	Base Period:	FY 96/97
Aid Code Grouping:	Aged				

The Rate Period is October 1, 1998 to September 30, 1999

Capitation Payments at the Beginning of the Month
C3 to Contract 95-23637
Attachment 1
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Coverages

CCS Indicated Claims	NOT Covered by the Plan
Mental Health Outpatient Services	NOT Covered by the Plan
Mental Health Pharmacy Costs	NOT Covered by the Plan
Mental Health Hospital Inpatient Services	NOT Covered by the Plan
Eyewear	NOT Covered by the Plan
Heroin Detoxification	NOT Covered by the Plan
AIDS Waiver Services	NOT Covered by the Plan
Adult Day Health Care	NOT Covered by the Plan
Chiropractor/Acupuncture	NOT Covered by the Plan
Local Education Authority	NOT Covered by the Plan
Alphafeto Protein Testing	NOT Covered by the Plan
Long Term Care for month of entry plus one	Covered by the Plan
Long Term Care after month of entry plus one	NOT Covered by the Plan
Special AIDS drugs	NOT Covered by the Plan

C3 to Contract
95-23637
Attachment 1
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Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other
1. Average Cost Per Unit	$ 48.90	$ 32.71	$ 316.16	$ 10.02	$ 77.33	$ 6.41
2. Units per Eligible	4.580	21.914	1.265	3.306	2.016	12.862
3. Addt'l Capitation Amts.	$ 1.29	$ 0.00	$ 7.41	$ 0.02	$ 0.00	$ 0.00
Cost per Elig. per Mo.	$ 19.95	$ 59.73	$ 40.74	$ 2.78	$ 12.99	$ 6.87
Adjustments						
a. Demographics	0.963	1.014	0.962	0.975	1.027	1.013
b. Area	1.043	1 000	1.000	1.000	1.000	1.000
c. Coverages	0.981	0.996	0.997	0.986	0.997	0.791
d. Interest	0.995	0.995	0.995	0.995	0.995	0.995
Adjusted Base Cost	$ 19.56	$ 60.02	$ 38.88	$ 2.66	$ 13.23	$ 5.48
3. Legislative Adjs.	0.939	1.049	0.926	0.931	1.140	0.927
4. Trend Adjustments						
a. Cost per Unit	1.100	1.100	1.100	1.050	1.000	1.050
b. Units per Eligble	1.100	1.155	1.100	1.100	1.000	0.950
Projected Cost per Eligible	$ 22.22	$ 79.99	$ 43.56	$ 2.86	$ 15.08	$ 5.07
5. Stop Loss Reins.	Amount		$ 0	Rate		0.0%
6. CHDP						
7. Fee-for-Service Adj.						-3.0%
Capitation Rate With FQHC Increment		$ 163.77 / Without		$ 163.77		

Rate Calculation	FFSE	FQHC Increment	Total
1. Average Cost Per Unit	$ 50.63	$ 0.00	
2. Units per Eligible	0.024	0.024	
3. Addt'l Capitation Amis.	$ 0.00	$ 0.00	
Cost per Elig. per Mo.	$ 0.10	$ 0.00	$ 143.16
Adjustments			
a. Demographics	0.979	0.979	
b. Area	1.000	1.000	
c. Coverages	0.603	0.603	
d. Interest	0.995	0.995	
Adjusted Base Cost	$ 0.06	$ 0.00	$ 139.89
3. Legislative Adjs.	0.926	0.926	
4. Trend Adjustments			
a. Cost per Unit	1.000	1.000	
b. Units per Eligible	1.000	1.000	

Projected Cost per Eligible	$ 0.06	$ 0.00	$ 168.84
5. Stop Loss Reins.	Premium		0.00
6. CHDP			0.00
7. Fee-for-Service Adj.			(5.07)
Capitation Rate With FQHC Increment			

The Rate Period is October 1, 1998 to September 30, 1999   Capitation Payments at the Beginning of the Month

Coverages

CCS Indicated Claims	NOT Covered by the Plan
Mental Health Outpatient Services	NOT Covered by the Plan
Mental Health Pharmacy Costs	NOT Covered by the Plan
Mental Health Hospital Inpatient Services	NOT Covered by the Plan
Eyewear	NOT Covered by the Plan
Heroin Detoxification	NOT Covered by the Plan
AIDS Waiver Services	NOT Covered by the Plan
Adult Day Health Care	NOT Covered by the Plan
Chiropractor/Acupuncture	NOT Covered by the Plan
Local Education Authority	NOT Covered by the Plan
Alphafelo Protein Testing	NOT Covered by the Plan
Long Term Care for month of entry plus one	Covered by the Plan
Long Term Care alter month of entry plus one	NOT Covered by the Plan
Special AIDS drugs	NOT Covered by the Plan

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other
1. Average Cost Per Unit	$ 67.42	$ 13.64	$ 1,120.53	$ 16.21	$ 469.38	$ 20.69
2. Units per Eligible	4.035	3.411	0.465	1.516	0.007	1.958
3. Addt'l Capitation Amts.	$ 0.23	$ 0.03	$ 2.90	$ 0.00	$ 0.00	$ 0.00
Cost per Elig. per Mo.	$ 22.90	$ 3.91	$ 46.32	$ 2.05	$ 0.27	$ 3.38
Adjustments						
a. Demographics	1.212	1.021	1.342	1.157	1.000	1.080
b. Area	1.043	1.000	1.000	1.000	1.000	1.000
c. Coverages	0.974	0.984	0.952	0.973	0.996	0.815
d. Interest	0.995	0.995	0.995	0.995	0.995	0.995
Adjusted Base Cost	$ 28.05	$ 3.91	$ 58.88	$ 2.30	$ 0.27	$ 2.96
3. Legislative Adjs.	1.076	1.047	0.999	1.024	1.134	1.090
4. Trend Adjustments						
a. Cost per Unit	1.000	1.100	1.050	1.000	1.000	0.950
b. Units per Eligible	0.950	1.000	1.050	0.950	1.050	1.050
Projected Cost per Eligible	$ 28.67	$ 4.50	$ 64.85	$ 2.24	$ 0.32	$ 3.22
5. Stop Loss Reins.	Amount		$ 0		Rate	0.0%
6. CHDP						
7. Fee-for-Service Adj.						-3.0%
Capitation Rate With FQHC Increment		$ 106.43 / Without		$ 106.35		

Rate Calculation	FFSE	FQHC Increment	Total
1. Average Cost Per Unit	$ 68.10	$ 7.33	
2. Units per Eligible	0.132	0.132	
3. Addt'l Capitation Amts.	$ 0.00	$ 0.00	
Cost per Elig. per Mo.	$ 0.75	$ 0.08	$ 79.66
Adjustments			
a. Demographics	1.084	1.084	
b. Area	1.000	1.000	
c. Coverages	0.970	0.970	
d. Interest	0.995	0.995	
Adjusted Base Cost	$ 0.78	$ 0.08	$ 97.23
3. Legislative Adjs.	1.031	1.031	
4. Trend Adjustments			
a. Cost per Unit	1.000	1.000	
b. Units per Eligible	1.000	1.000	
Projected Cost per Eligible	$ 0.80	$ 0.08	$ 104.88
5. Stop Loss Reins.	Premium		0.00
6. CHDP			5.04
7. Fee-for-Service Adj.			(3.29)
Capitation Rate With FQHC Increment			

The Rate Period is October 1, 1998 to September 30, 1999 Capitation Payments at the Beginning of the Month

Coverages

CCS Indicated Claims	NOT Covered by the Plan
Mental Health Outpatient Services	NOT Covered by the Plan
Mental Health Pharmacy Costs	NOT Covered by the Plan
Mental Health Hospital Inpatient Services	NOT Covered by the Plan
Eyewear	NOT Covered by the Plan
Heroin Detoxification	NOT Covered by the Plan
AIDS Waiver Services	NOT Covered by the Plan
Adult Day Health Care	NOT Covered by the Plan
Chiropractor/Acupuncture	NOT Covered by the Plan
Local Education Authority	NOT Covered by the Plan
Alphafeto Protein Testing	NOT Covered by the Plan
Long Term Care for month of entry plus one	Covered by the Plan
Long Term Care after month of entry plus one	NOT Covered by the Plan
Special AIDS drugs	NOT Covered by the Plan

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other
1. Average Cost Per Unit	$ 90.48	$ 17.11	$ 1,140.81	$ 15.76	$ 812.04	$ 36.13
2. Units per Eligible	21.541	5.818	5.446	4.679	0.000	10.172
3. Addt'l Capitation Amts.	$ 0.37	$ 0.06	$ 35.62	$ 0.08	$ 0.00	$ 0.00
Cost per Elig. per Mo.	$ 162.79	$ 8.36	$ 553.36	$ 6.23	$ 0.00	$ 30.63
Adjustments						
a. Demographics	1.000	1.000	1.000	1.000	1.000	1.000
b. Area	1.043	1.000	1.000	1.000	1.000	1.000
c. Coverages	0.999	0.999	0.999	0.989	1.000	0.809
d. Interest	0.995	0.995	0.995	0.995	0.995	0.995
Adjusted Base Cost	$ 168.77	$ 8.31	$ 550.04	$ 6.13	$ 0.00	$ 24.66
3. Legislative Adjs.	1.029	1.054	1.000	1.022	1.102	1.004
4. Trend Adjustments						
a. Cost per Unit	1.000	1.100	1.050	1.000	1.000	0.950
b. Units per Eligble	0.950	1.000	1.050	0.950	1.050	1.050
Projected Cost per Eligible	$ 164.98	$ 9.63	$ 606.42	$ 5.95	$ 0.00	$ 24.70
5. Stop Loss Reins.	Amount		$ 0		Rate	0.0%
6. CHDP						
7. Fee-for-Service Adj.						-3.0%
Capitation Rate With FQHC Increment		$ 790.89 / Without		$ 790.53		

Rate Calculation	FFSE	FQHC Increment	Total
1. Average Cost Per Unit	$ 68.10	$ 7.33	
2. Units per Eligible	0.577	0.577	
3. Addt'l Capitation Amts.	$ 0.00	$ 0.00	
Cost per Elig. per Mo.	$ 3.28	$ 0.35	$ 765.00
Adjustments			
a. Demographics	1.000	1.000	
b. Area	1.000	1.000	
c. Coverages	0.995	0.995	
d. Interest	0.995	0.995	
Adjusted Base Cost	$ 3.25	$ 0.35	$ 761.51
3. Legislative Adjs.	1.015	1.015	
4. Trend Adjustments			
a. Cost per Unit	1.000	1.000	
b. Units per Eligble	1.000	1.000	
Projected Cost per Eligible	$ 3.30	$ 0.36	$ 815.34
5. Stop Loss Reins.	Premium		0.00
6. CHDP			0.00
7. Fee-for-Service Adj.			(24.45)
Capitation Rate With FQHC Increment			

The Rate Period is October 1, 1998 to September 30, 1999   Capitation Payments at the Beginning of the Month

Coverages

Coverage	Status
CCS Indicated Claims	NOT Covered by the Plan
Mental Health Outpatient Services	NOT Covered by the Plan
Mental Health Pharmacy Costs	NOT Covered by the Plan
Mental Health Hospital Inpatient Services	NOT Covered by the Plan
Eyewear	NOT Covered by the Plan
Heroin Detoxification	NOT Covered by the Plan
AIDS Waiver Services	NOT Covered by the Plan
Adult Day Health Care	NOT Covered by the Plan
Chiropractor/Acupuncture	NOT Covered by the Plan
Local Education Authority	NOT Covered by the Plan
Alphafeto Protein Testing	NOT Covered by the Plan
Long Term Care for month of entry plus one	Covered by the Plan
Long Term Care after month of entry plus one	NOT Covered by the Plan
Special AIDS drugs	NOT Covered by the Plan

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other
1. Average Cost Per Unit	$ 32.67	$ 126.04	$ 611.26	$ 13.79	$ 139.87	$ 42.30
2. Units per Eligible	26.584	74.792	3.169	9.882	0.000	36.392
3. Addt'l Capitation Amts.	$ 2.96	$ 0.09	$ 9.89	$ 0.02	$ 0.00	$ 0.00
Cost per Elig. per Mo.	$ 75.33	$ 785.66	$ 171.31	$ 11.38	$ 0.00	$ 128.28
Adjustments						
a. Demographics	1.000	1.000	1.000	1.000	1.000	1.000
b. Area	1.043	1.000	1.000	1.000	1.000	1.000
c. Coverages	0.918	0.648	0.957	0.992	0.998	0.599
d. Interest	0.995	0.995	0.995	0.995	0.995	0.995
Adjusted Base Cost	$ 71.77	$ 506.56	$ 163.12	$ 11.23	$ 0.00	$ 76.46
3. Legislative Adjs.	0.963	1.006	0.977	0.982	1.186	0.979
4. Trend Adjustments						
a. Cost per Unit	1.000	1.100	1.050	1.000	1.100	1.100
b. Units per Eligble	1.100	1.210	1.050	1.045	0.950	1.000
Projected Cost per Eligible	$ 76.03	$ 678.28	$ 175.70	$ 11.52	$ 0.00	$ 82.34
5. Stop Loss Reins.	Amount		$ 0	Rate		0.0%
6. CHDP						
7. Fee-for-Service Adj.						-3.0%
Capitation Rate With FQHC Increment		$ 995.00 / Without		$ 995.00		

Rate Calculation	FFSE	FQHC Increment	Total
1. Average Cost Per Unit	$ 69.96	$ 0.00	
2. Units per Eligible	0.349	0.349	
3. Addt'l Capitation Amts.	$ 0.00	$ 0.00	
Cost per Elig. per Mo.	$ 2.04	$ 0.00	$ 1,174.00
Adjustments			
a. Demographics	1.000	1.000	
b. Area	1.000	1.000	
c. Coverages	0.951	0.951	
d. Interest	0.995	0.995	
Adjusted Base Cost	$ 1.93	$ 0.00	$ 831.07
3. Legislative Adjs.	0.984	0.984	
4. Trend Adjustments			
a. Cost per Unit	1.000	1.000	
b. Units per Eligible	1.000	1.000	
Projected Cost per Eligible	$ 1.90	$ 0.00	$ 1,025.77
5. Stop Loss Reins.	Premium		0.00
6. CHDP			0.00
7. Fee-for-Service Adj.			(30.77)
Capitation Rate With FQHC Increment			

Aid Group Poverty - 7A

Base: Statewide Family Age Adjusted
Base Period : FY 96/97

Payments at End of Month

Services ==>>	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Nursing Facility	Other	FQHC FFSE	FQHC Increment	Total
1. Base Cost	$ 10.40	$ 6.74	$ 13.64	$ 3.91	$ 0.24	$ 8.30	$ 2.98	$ 1.21	$ 47.42
2. Age/Sex Adjustments	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	
3. Eligibility Adjustments	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	
4. Coverage Adjustments	0.997	0.997	0.999	0.964	1.000	0.891	0.991	0.991	
5. Interest Offset	0.995	1.001	0.991	0.993	0.998	0.995	0.998	0.998	
Contract Cost FY 96/97	$ 10.32	$ 6.73	$ 13.50	$ 3.74	$ 0.24	$ 7.36	$ 2.94	$ 1.20	$ 46.03
6. Legislative Adjustments	1.044	0.740	0.985	1.021	1.061	1.150	1.024	1.024	
7. Trend Adjustments									
a. Cost per Unit	1.000	1.308	1.055	0.970	1.000	1.445	1.071	1.071	
b. Utilization	1.000	1.027	1.050	1.000	1.107	1.000	1.265	1.265	
Projected Cost 10/98-9/99	$ 10.77	$ 6.69	$ 14.73	$ 3.70	$ 0.28	$ 12.23	$ 4.08	$ 1.66	$ 54.14
8. CHDP									$ 2.54
9. Adiministrative Allowance						1.6%			$ 0.88
Fee-for-Service Equivalent Cost									$ 57.56
Fee-for-Service Adj.						94%			(3.45)
Capition Rate with FQHC increment									$ 54.11
Capition Rate without FQHC increment									$ 52.55

Aid Group Poverty - 47/72 Base: Statewide Family Age Adjusted
Base Period : FY 96/97

Payments at End of Month

Services ==>>	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Nursing Facility	Other	FQHC FFSE	FQHC Increment	Total
1. Base Cost	$ 10.66	$ 7.27	$ 20.52	$ 5.31	$ 0.14	$ 2.92	$ 5.42	$ 2.21	$ 54.45
2. Age/Sex Adjustments	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	
3. Eligibility Adjustments	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	
4. Coverage Adjustments	0.997	0.997	0.999	0.964	1.000	0.891	0.991	0.991	
5. Interest Offset	0.995	1.001	0.991	0.993	0.998	0.995	0.998	0.998	
Contract Cost FY 96/97	$ 10.57	$ 7.25	$ 20.32	$ 5.09	$ 0.14	$ 2.59	$ 5.36	$ 2.18	$ 53.50
6. Legislative Adjustments	1.044	0.740	0.985	1.021	1.061	1.150	1.024	1.024	
7. Trend Adjustments									
a. Cost per Unit	1.000	1.308	1.055	0.970	1.000	1.445	1.071	1.071	
b. Utilization	1.000	1.027	1.050	1.000	1.107	1.000	1.265	1.265	
Projected Cost 10/98-9/99	$ 11.04	$ 7.21	$ 22.17	$ 5.04	$ 0.16	$ 4.30	$ 7.44	$ 3.02	$ 60.38
8. CHDP									$ 12.54
9. Adiministrative Allowance						1.5%			$ 0.96
Fee-for-Service Equivalent Cost									$ 63.88
Fee-for-Service Adj.						94%			(3.83)
Capition Rate with FQHC increment									$ 60.05
Capition Rate without FQHC increment									$ 57.21

[LETTERHEAD OF DEPARTMENT OF HEALTH SERVICES]

DEPARTMENT OF HEALTH SERVICES
714/744 P Street
P. O. Box 942732
Sacramonto, CA 94234-7320
(916) 654-8076

December 23, 1999

George Goldstein, President
Molina Medical Centers
One Golden Shore
Long Beach, CA 90802

Dear Mr. Goldstein:

The enclosed Change Order No. C4 to Contract No. 95-23637 adds Section 3.47 to Article III of your Contract, relating to Year 2000 compliance requirements. The text of the Change Order contains the State Department of General Services Year 2000 warranty language. The Change Order will be effective immediately. Alternative text is not permitted.

If you have any questions, please contact your contract manager.

Sincerely,

/s/

Susanne M. Hughes
Acting Chief
Medi-Cal Managed Care Division

Enclosures

[LETTERHEAD OF DEPARTMENT OF HEALTH SERVICES]

DEPARTMENT OF HEALTH SERVICES
714/744 P Street
P. O. Box 942732
Sacramento. CA 94234-7320
(916) 654-8076

CHANGE ORDER No. C4 to CONTRACT No. 95-23637: AMEND ARTICLE III, GENERAL TERMS AND CONDITIONS BY ADDING SECTION 3.47, YEAR 2000 COMPLIANCE REQUIREMENTS. Issued December 17, 1999.

3.47 YEAR 2000 COMPLIANCE REQUIREMENTS

The Contractor warrants and represents that the goods or services sold, leased, or licensed to the State of California, its agencies, or its political subdivisions, pursuant to this contract are "Year 2000 compliant." For purposes of this contract, a good or service is Year 2000 compliant If it will continue to fully function before, at, and after the Year 2000 without interruption and if applicable, with full ability to accurately and unambiguously process, display, compare, calculate, manipulate, and otherwise utilize date information. This warranty and representation supersedes all warranty disclaimers and all limitations on liability provided by or through the Contractor.

[GRAPHIC APPEARS HERE]

DEPARTMENT OF HEALTH SERVICES
714/744 P Street
P.O. Box 42732
Sacramento, CA 94234-7320
(916) 654-8076

February 7, 2000

[SEAL]

George Goldstein
Molina Medical Centers, Inc.
One Golden Shore
Long Beach, CA 90802

Dear Mr., Goldstein:

On July 1, 1999, the Department of Health Services (Department) sent you Change Order No. 03 to Contract No. 95-23637. After further analysis, the Department determined that Change Order No. 03 did not completely express its intent regarding Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs). In addition, this Change Order adds several new aid codes that became effective during 1999. These aid codes are split aid codes from existing aid codes you are already capitated for, including 5X split from 59, 8R split from 7A, and 8P spirt from 72. Therefore, the Department is sending you this enclosed Change Order (No. 05) to replace and supersede Change Order No. 03.

In accordance with Article III, Section 3.34.2 of your Contract, the enclosed Change Order authorizes the change in rates for FQHC and RHC subcontracts and transmits (Molina Medical Centers, Inc.) rates for the period July 1, 1999 through September 30, 1 999. This Change Order also changes Contract Sections 3.28.6 Federally Qualified Health Centers/Rural Health Clinics; 5.3 Capitation Rates; 5.4 Capitation Rates Constitute Payment in Full; 5.13 FQHC and RHC Risk Corridor Payments; 6.3,6 Submittal of FQHC and RHC Payment Information and 6.6.21 FQHC and RHC Contracts. These rates appeared in your capitation rates beginning July 1, 1999.

If you have any questions, please contact your contract manager.

Sincerely,

/s/

Susanne M. Hughes
Acting Chief
Medi-Cal Managed Care Division

Enclosures

[LETTERHEAD OF DEPARTMENT OF HEALTH SERVICES]

DEPARTMENT OF HEALTH SERVICES
714/744 P Street
P. O. Box 942732
Sacramento, CA 94234-7320
(916)654-8076

CHANGE ORDER NUMBER C5 TO CONTRACT NO.95-23637: CHANGING CONTRACT SECTIONS 3.28.6 FEDERALLY QUALIFIED HEALTH CENTERS/RURAL HEALTH CLINICS; 5.3 CAPITATION RATES; 5.4 CAPITATION RATES CONSTITUTE PAYMENT IN FULL; 5.13 FQHC/RHC RISK CORRIDOR PAYMENTS; 6.3.6 SUBMITTAL OF FQHC AND RHC PAYMENT INFORMATION AND 6.6.21 FQHC AND RURAL HEALTH CLINIC (RHC) CONTRACTS TO READ AS STATED BELOW. This Change Order is effective July 1,1999.

1. 3.28.6 FEDERALLY QUALIFIED HEALTH CENTERS/RURAL HEALTH CLINICS

   A. For service periods from the effective date of this contract through June 30,1999, Contractor shall not enter into a Subcontract with a Federally Qualified Health Center (FQHC) or a Rural Health Clinic (RHC) unless DHS approves the provisions regarding rates, which shall be subject to the standard that they be reasonable, as determined by DHS, in relation to the services to be provided in accordance with Article VI, Section 6.6.21, FQHC and RHC Contracts. In Subcontracts where the FQHC or RHC has made the election to be reimbursed on a reasonable cost basis by the State, provisions shall be included that require the subcontractor to keep a record of the number of visits by plan Members separate from Fee-For-Service Medi-Cal beneficiaries, in addition to any other data reporting requirements of the Subcontract

   B. For service periods beginning July 1,1999, Contractor shall submit to DHS, within 30 days of a request and in the form and manner specified by DHS, the services provided and the reimbursement level and amount for each of Contractor's FQHC and RHC Subcontracts. For service periods beginning July 1,1999, Contractor shall certify in writing to DHS within 30 days of DHS's written request, that pursuant to Welfare and Institutions Code, Section 14087.325(b) and (d), as amended by Chapter 894/Statutes of 1998, FQHC and RHC Subcontract terms and conditions are the same as offered to other Subcontractors providing a similar scope of service and that reimbursement is not less than the level and amount of payment that Contractor makes for the same scope of services furnished by a provider that is not a FQHC or RHC. For FQHC or RHC services provided on or after July 1,1999, Contractor is not required to pay FQHCs and RHCs the Medi-Cal interim per visit rate described in Section 6.6.21. At its discretion, DHS reserves the right to review and audit Contractor's FQHC and RHC reimbursement to ensure compliance with state and federal law and shall approve all FQHC and RHC Subcontracts consistent with the provisions of Welfare and Institutions Code Section 14087.325(h).

C. Subcontracts with FQHCs shall also meet Contract requirements of Article VI, Sections 6.6.20, FQHC Services, and 6.6.21, FQHC and Rural Health Clinic Contracts. Subcontracts with RHCs shall also meet Contract requirements of Article VI, Section 6.6.21.

D. In Subcontracts where a negotiated reimbursement rate is agreed to as total payment, a provision that such rate constitutes total payment shall be included in the Subcontract

2. 5.3 CAPITATION RATES

For the period 7/1/99-9/30/99 Riverside County

GROUPS	AID CODES	RATE
Family	01, OA, 02, 08, 30, 32, 33, 34, 35, 38, 39, 40, 42, 54, 59, 3A, 3C, 3E, 3G, 3H, 3L 3M, 3N, 3P, 3R, 3U, 5X, 7X,	$ 78.41
Disabled	20, 24, 26, 28, 36, 60, 64, 66, 68, 6A, 6C, 6N, 6P, 6R	$ 222.61
Aged	10,14,16,18	$ 160.47
Child	03,04,4C,4K, 5K, 45, 82	$ 92.75
Adult	86	$ 705.26
AIDS Beneficiary	.	$ 962.42
Percent of Poverty	7A, 8R	$ 52.55
Percent of Poverty	47, 72, 8P	$ 57.21

For the period 7/1/99 -9/30/99 San Bernardino County

GROUPS	AID CODES	RATE
Family	01,OA,02,08, 30, 32, 33, 34, 35, 38, 39, 40, 42, 54, 59, 3A, 3C, 3E, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 5X, 7X,	$ 80.41
Disabled	20, 24, 26, 28, 36, 60, 64, 66, 68, 6A, 6C, 6N, 6P, 6R	$ 233.49
Aged	10, 14, 16, 18	$ 163.77
Child	03, 04, 4C, 4K, 5K, 45, 82	$ 106.35
Adult	86	$ 790.53
AIDS Beneficiary		$ 995.00
Percent of Poverty	7A, 8R	$ 52.55
Percent of Poverty	47, 72, 8P	$ 57.21

All other terms, conditions, and provisions contained in Section 5.3 remain unchanged.

3. 5.4 CAPITATION RATES CONSTITUTE PAYMENT IN FULL

Capitation rates for each rate period, as calculated by DHS, are prospective rates and constitute payment in full, subject to any stop loss reinsurance provisions, on behalf of a Member for all Covered Services required by such Member and for all Administrative Costs incurred by the Contractor in providing or arranging for such services, and subject to adjustments for federally qualified health centers in accordance with Section 5.13, but do not include payment for the recoupment of current or previous losses incurred by Contractor. DHS is not responsible for making payments for recoupment of losses. The actuarial basis for the determination of the capitation payment rates is outlined in Attachment 1 (consisting of 16 pages).

4. 5.13 FQHC/RHC RISK CORRIDOR PAYMENTS

For FQHCs/RHCs service periods beginning October 1,1997, and continuing through June 30,1999, provided that Contractor has submitted expenditure data to DHS in the form and manner specified by DHS, DHS shall perform reconciliations to determine the variance between the funds that have been paid to the Contractor in its capitation rates to reflect the dollar value of FQHC/RHC interim rate payments made to these entities in the

Medi-Cal fee-for-service program, and the amount that the Contractor has paid to subcontracting FQHCs/RHCs.

For the initial reconciliation and for each reconciliation thereafter, if, pursuant to subcontracts with FQHCs and RHCs that have been reviewed and approved by DHS, Contractor has paid subcontracting FQHCs and RHCs in the aggregate an amount greater than 110 percent of the dollar value of FQHC and RHC interim rate payments included in Contractor's capitation rates, DHS shall pay Contractor the amount in excess of 110 percent.

For the initial reconciliation and for each reconciliation thereafter, if, pursuant to subcontracts with FQHCs and RHCs that have been reviewed and approved by DHS, Contractor has paid subcontracting FQHCs and RHCs in the aggregate an amount less than 90 percent of the dollar value of FQHC and RHC interim rate payments included in Contractor's capitation rates, Contractor shall refund the amount below 90 percent to DHS. DHS may recover amounts owed by Contractor pursuant to this section through an offset to the capitation payments made to Contractor, pursuant to Section 5.11(C), Recovery of Capitation Payments.

All reconciliations shall be subject to an annual reconciliation audit at which time payments to or recoupment from Contractor shall be finalized.

5. 6.3.6 SUBMITTAL OF FQHC AND RHC PAYMENT INFORMATION

Effective with the October 1997 month of service. Contractor shall keep a record of the number of visits by plan Members to each FQHC and RHC contracting with Contractor and related payment information, and shall submit this information to DHS in the frequency, format, and manner specified by DHS. -This requirement shall remain in effect for service periods through the September 2000 month of service.

6. 6.6.21 FQHO AND RURAL HEALTH CLINIC (RHC) CONTRACTS

A. For service periods beginning October 1,1997, and continuing through June 30,1999, notwithstanding Article III, Section 3.26.4, Departmental Approval - Federally Qualified HMOs, Contractor shall not enter into any contract with an FQHC or RHC for provision of Covered Services to Members without prior written approval by DHS. All contracts with FQHCs or RHCs shall provide reimbursement to the FQHC or RHC on the basis of each center's or clinic's Medi-Cal interim per visit rate, applicable on the date the reimbursable services were provided, as established by DHS, unless:

   1. DHS has approved in writing an alternate reimbursement methodology, or

2. The FQHC or RHC agrees to be reimbursed on an at-risk basis and such agreement is contained in the contract with the center or clinic. In contracts where a negotiated rate is agreed to as total payment, the contract shall state that such payment' constitutes total payment to the entity.

B. To the extent that Indian Health Service facilities qualify as FQHCs or RHCs, the same reimbursement requirements shall apply to contracts with Indian Health Service facilities.

Plan Name:	Molina Medical Center	Plan #:	355	Date:	04-May-99	Attachment 1
County:	Riverside	Plan Type:	Commercial Plan	Base Period:	FY 96/97	

The Rate Period is October 1, 1998 to September 30, 1999   Capitation Payments at the Beginning of the Month

Coverages

Coverage	Status
CCS Indicated Claims	NOT Covered by the Plan
Mental Health Outpatient Services	NOT Covered by the Plan
Mental Health Pharmacy Costs	NOT Covered by the Plan
Mental Health Hospital Inpatient Services	NOT Covered by the Plan
Eyewear	NOT Covered by the Plan
Heroin Deloxification	NOT Covered by the Plan
AIDS Waiver Services	NOT Covered by the Plan
Adult Day Health Care	NOT Covered by the Plan
Chiropractor/Acupuncture	NOT Covered by the Plan
Local Education Authority	NOT Covered by the Plan
Alphafelo Protein Testing	NOT Covered by the Plan
Long Term Care for month of entry plus one	Covered by the Plan
Long Term Care after month of entry plus one	NOT Covered by the Plan
Special AIDS drugs	NOT Covered by the Plan

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other
1. Average Cost Per Unit	$ 69.46	$ 19.88	$ 864.71	$ 16.16	$ 812.04	$ 20.09
2. Units per Eligible	4.014	4.683	0.373	2.146	0.004	3.532
3. Addt'l Capitation Amts.	$ 0.37	$ 0.05	$ 4.62	$ 0.01	$ 0.00	$ 0.00
Cost per Elig. per Mo.	$ 23.60	$ 7.81	$ 31.50	$ 2.90	$ 0.27	$ 5.91
Adjustments						
a. Demographics	1.004	0.976	1.023	1.002	1.000	0.085
b. Area	1.043	1.000	1.000	1.000	1.000	1.000
c. Coverages	0.975	0.992	0.968	0.956	0.995	0.833
d. Interest	0.995	0.995	0.995	0.995	0.995	0.995
Adjusted Base Cost	$ 23.97	$ 7.52	$ 31.04	$ 2.76	$ 0.27	$ 4.82
3. Legislative Adjs.	1.053	1.053	0.998	1.023	1.141	1.046
4. Trend Adjustments						
a. Cost per Unit	1.000	1.100	1.050	1.000	1.000	0.950
b. Units per Eligible	0.050	1.000	1.050	0.950	1.050	1.050
Projected Cost per Eligible	$ 23.98	$ 8.71	$ 34.15	$ 2.68	$ 0.32	$ 5.03
5. Stop Loss Reins.	Amount		$ 0	Rate		0.0%
6. CHDP						
7. Fee-for-Service Adj.						-3.0%
Capitation Rate With FQHC Increment		$ 78.73 / Without		$ 78.41		

Rate Calculation	FFSE	FQHC Increment	Total
1. Average Cost Per Unit	$ 68.39	$ 24.41	
2. Units per Eligible	0.168	0.168	
3. Addt'l Capitation Amts.	$ 0.00	$ 0.00	
Cost per Elig. per Mo.	$ 0.96	$ 0.34	$ 73.29
Adjustments			
a. Demographics	0.994	0.994	
b. Area	1.000	1.000	
c. Coverages	0.935	0.935	
d. Interest	0.995	0.995	
Adjusted Base Cost	$ 0.89	$ 0.31	$ 71.58
3. Legislative Adjs.	1.027	1.027	
4. Trend Adjustments			
a. Cost per Unit	1.000	1.000	
b. Units per Eligible	1.000	1.000	
Projected Cost per Eligible	$ 0.91	$ 0.32	$ 76.10
5. Stop Loss Reins.	Premium		0.00
6. CHDP			5.06
7. Fee-for-Service Adj.			(2.43)
Capitation Rate With FQHC Increment			

Plan Name:	Molina Medical Center	Plan #:	355	Date:	04-May-99
County:	Riverside	Plan Type:	Commercial Plan	Base Period:	FY 96/97
Aid Code Grouping:	Disabled				

The Rate Period is October 1, 1998 to September 30, 1999   Capitation Payments at the Beginning of the Month

C5 to Contract 95-23637
Attachment 1

Coverages

Coverage	Status
CCS Indicated Claims	NOT Covered by the Plan
Mental Health Outpatient Services	NOT Covered by the Plan
Mental Health Pharmacy Costs	NOT Covered by the Plan
Mental Health Hospital Inpatient Services	NOT Covered by the Plan
Eyewcar	NOT Covered by the Plan
Heroin Detoxification	NOT Covered by the Plan
AIDS Waiver Services	NOT Covered by the Plan
Adult Day Health Care	NOT Covered by the Plan
Chiropractor/Acupuncture	NOT Covered by the Plan
Local Education Authority	NOT Covered by the Plan
Alphafelo Protein Testing	NOT Covered by the Plan
Long Term Care for month of entry plus one	Covered by the Plan
Long Term Care after month of entry plus one	NOT Covered by the Plan
Special AIDS drugs	NOT Covered by the Plan

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other
1. Average Cost Per Unit	$ 46.41	$ 39.70	$ 485.15	$ 12.37	$ 139.87	$ 10.16
2. Units per Eligible	6.873	26.861	1.556	5.050	0.459	21.959
3. Addt'l Capitation Amts.	$ 2.96	$ 0.09	$ 9.89	$ 0.02	$ 0.00	$ 0.00
Cost per Elig. per Mo.	$ 29.54	$ 88.96	$ 72.80	$ 5.23	$ 5.35	$ 18.59
Adjustments						
a. Demographics	0.983	0.989	0.981	0.998	1.000	1.015
b. Area	1.043	1.000	1.000	1.000	1.000	1.000
c. Coverages	0.900	0.875	0.920	0.973	0.995	0.878
d. Interest	0.995	0.995	0.995	0.995	0.995	0.995
Adjusted Base Cost	$ 27.12	$ 76.60	$ 65.37	$ 5.05	$ 5.30	$ 16.48
3. Legislative Adjs.	0.941	1.043	0.919	0.931	1.130	0.923
4. Trend Adjustments						
a. Cost per Unit	1.000	1.100	1.050	1.000	1.100	1.100
b. Units per Eligible	1.100	1.210	1.050	1.045	0.950	1.000
Projected Cost per Eligible	$ 28.07	$ 106.34	$ 66.23	$ 4.91	$ 6.26	$ 16.73
5. Stop Loss Reins.	Amount		$ 0	Rate		0.0%
6. CHDP						
7. Fee-for-Service Adj.						-3.0%
Capitation Rate With FQHC Increment		$ 222.61 / Without		$ 222.61		

Rate Calculation	FFSE	FQHC Increment	Total
1. Average Cost Per Unit	$ 66.52	$ 0.00	
2. Units per Eligible	0.216	0.216	
3. Addt'l Capitation Amts.	$ 0.00	$ 0.00	
Cost per Elig. per Mo.	$ 1.20	$ 0.00	$ 221.67
Adjustments			
a. Demographics	0.987	0.987	
b. Area	1.000	1.000	
c. Coverages	0.863	0.863	
d. Interest	0.995	0.995	
Adjusted Base Cost	$ 1.02	$ 0.00	$ 196.94
3. Legislative Adjs.	0.932	0.932	
4. Trend Adjustments			
a. Cost per Unit	1.000	1.000	
b. Units per Eligble	1.000	1.000	
Projected Cost per Eligible	$ 0.95	$ 0.00	$ 229.49
5. Stop Loss Reins.	Premium		0.00
6. CHDP			0.00
7. Fee-for-Service Adj.			(8.88)
Capitation Rate With FQHC Increment			

Plan Name: Molina Medical Center   Plan #: 355   Date: 04-May-99
County: Riverside   Plan Type: Commercial Plan   Base Period: FY 96/97
Aid Code Grouping: Aged

The Rate Period is October 1, 1998 to September 30, 1999   Capitation Payments at the Beginning of the Month

Coverages

Coverage	Status
CCS Indicated Claims	NOT Covered by the Plan
Mental Health Outpatient Services	NOT Covered by the Plan
Mental Health Pharmacy Costs	NOT Covered by the Plan
Mental Health Hospital Inpatient Services	NOT Covered by the Plan
Eyewear	NOT Covered by the Plan
Heroin Detoxification	NOT Covered by the Plan
AIDS Waiver Services	NOT Covered by the Plan
Adult Day Health Care	NOT Covered by the Plan
Chiropractor/Acupuncture	NOT Covered by the Plan
Local Education Authority	NOT Covered by the Plan
Alphafelo Protein Testing	NOT Covered by the Plan
Long Term Care for month of entry plus one	Covered by the Plan
Long Term Care alter month of entry plus one	NOT Covered by the Plan
Special AIDS drugs	NOT Covered by the Plan

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other
1. Average Cost Per Unit	$ 48.90	$ 32.71	$ 287.24	$ 10.02	$ 77.33	$ 6.41
2. Units per Eligible	4.472	21.014	1.265	3.306	2.016	12.862
3. Addt'l Capitation Amts.	$ 1.29	$ 0.00	$ 7.41	$ 0.02	$ 0.00	$ 0.00
Cost per Elig. per Mo.	$ 19.51	$ 59.73	$ 37.69	$ 2.78	$ 12.99	$ 6.87
Adjustments						
a. Demographics	0.955	1.019	0.957	0.970	1.039	1.025
b. Area	1.043	1.000	1.000	1.000	1.000	1.000
c. Coverages	0.981	0.996	0.997	0.986	0.997	0.791
d. Interest	0.995	0.995	0.995	0.995	0.995	0.995
Adjusted Base Cost	$ 18.97	$ 60.32	$ 35.78	$ 2.65	$ 13.39	$ 5.54
3. Legislative Adjs.	0.939	1.049	0.926	0.931	1.140	0.927
4. Trend Adjustments						
a. Cost per Unit	1.100	1.100	1.100	1.050	1.000	1.050
b. Units per Eligible	1.100	1.155	1.100	1.100	1.000	0.950
Projected Cost per Eligible	$ 21.55	$ 80.39	$ 40.09	$ 2.85	$ 15.28	$ 5.12
5. Stop Loss Reins.	Amount		$ 0		Rate	0.0%
6. CHDP						
7. Fee-for-Service Adj.						-3.0%
Capitation Rate With FQHC Increment		$ 160.47 / Without		$ 160.47		

Rate Calculation	FFSE	FQHC Increment	Total
1. Average Cost Per Unit	$ 28.59	$ 0.00	
2. Units per Eligible	0.132	0.132	
3. Addt'l Capitation Amts.	$ 0.00	$ 0.00	
Cost per Elig. per Mo.	$ 0.31	$ 0.00	$ 139.88
Adjustments			
a. Demographics	0.970	0.970	
b. Area	1.000	1.000	
c. Coverages	0.603	0.603	
d. Interest	0.995	0.995	
Adjusted Base Cost	$ 0.18	$ 0.00	$ 136.83
3. Legislative Adjs.	0.926	0.926	
4. Trend Adjustments			
a. Cost per Unit	1.000	1.000	
b. Units per Eligible	1.000	1.000	
Projected Cost per Eligible	$ 0.17	$ 0.00	$ 165.43
5. Stop Loss Reins.	Premium		0.00
6. CHDP			0.00
7. Fee-for-Service Adj.			(4.96)
Capitation Rate With FQHC Increment			

Plan Name:	Molina Medical Center	Plan#:	355	Date:	04-May-00
County:	Riverside	Plan Type:	Commercial Plan	Base Period:	FY 96/97
Ald Code Grouping:	Child				

The Rale Period is October 1,1998 to September 30, 1999

Capitation Payments at the Beginning of the Month

Coverages

Coverage	Status
CCS Indicated Claims	NOT Covered by the Plan
Mental Health Outpatient Services	NOT Covered by the Plan
Mental Health Pharmacy Costs	NOT Covered by the Plan
Mental Health Hospital Inpatient Services	NOT Covered by the Plan
Eyewear	NOT Covered by the Plan
Heroin Detoxification	NOT Covered by the Plan
AIDS Waiver Services	NOT Covered by the Plan
Adult Day Health Care	NOT Covered by the Plan
Chiropractor/Acupuncture	NOT Covered by the Plan
Local Education Authority	NOT Covered by the Plan
Alphateto Protein Testing	NOT Covered by the Plan
Long Term Care for month of entry plus one	Covered by the Plan
Long Term Care after month of entry plus one	NOT Covered by the Plan
Special AIDS drugs	NOT Covered by the Plan

C5 to Contract 95-23637
Attachment 1

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care
1. Average Cost Per Unit	$ 67.42	$ 13.64	$ 889.41	$ 16.21	$ 469.38
2. Units per Eligible	3.999	3.411	0.465	1.516	0.007
3. Addt'l Capitation Amts.	$ 0.23	$ 0.03	$ 2.90	$ 0.00	$ 0.00
Cost per Elig. per Mo.	$ 22.70	$ 3.91	$ 37.86	$ 2.05	$ 0.27
Adjustments					
a. Demographics	1.181	1.019	1.321	1.114	1.000
b. Area	1.043	1.000	1.000	1.000	1.000
c. Coverages	0.974	0.984	0.952	0.973	0.996
d. Interest	0.995	0.995	0.995	0.995	0.995
Adjusted Base Cost	$ 27.10	$ 3.90	$ 46.75	$ 2.21	$ 0.27
3. Legislative Adjs.	1.076	1.047	0.999	1.024	1.134
4. Trend Adjustments					
a. Cost per Unit	1.000	1.100	1.050	1.000	1.000
b. Units per Eligible	0.950	1.000	1.050	0.950	1.050
Projected Cost per Eligible	$ 27.70	$ 4.49	$ 51.49	$ 2.15	$ 0.32
5. Stop Loss Reins		Amount	$ 0		
6. CHDP					
7. Fee-for-Service Adj.					
Capitation Rate With FQHC Increment		$ 93.09 / Without		$ 92.75	

Rate Calculation		Other	FFSE	FQHC Increment	Total
1. Average Cost Per Unit		$ 20.69	$ 68.39	$ 24.41	
2. Units per Eligible		1.958	0.168	0.168	
3. Addt'l Capitation Amts.		$ 0.00	$ 0.00	$ 0.00	
Cost per Elig. per Mo.		$ 3.38	$ 0.96	$ 0.34	$ 70.97
Adjustments					
a. Demographics		1.165	1.003	1.003	
b. Area		1.000	1.000	1.000	
c. Coverages		0.815	0.970	0.970	
d. Interest		0.995	0.995	0.995	
Adjusted Base Cost		$ 3.19	$ 0.93	$ 0.33	$ 84.68
3. Legislative Adjs.		1.090	1.031	1.031	
4. Trend Adjustments					
a. Cost per Unit		0.950	1.000	1.000	
b. Units per Eligible		1.050	1.000	1.000	
Projected Cost per Eligible		$ 3.47	$ 0.96	$ 0.34	$ 90.92
5. Stop Loss Reins.	Rate	0.0%	Premium		0.00
6. CHDP					5.04
7. Fee-for-Service Adj.		-3.0%			(2.87)
Capitation Rate With FQHC Increment					

Plan Name:	Molina Medical Center	Plan#:	355	Date:	04-May-00
County:	Riverside	Plan Type:	Commercial Plan	Base Period:	FY 96/97
Ald Code Grouping:	Adult				

The Rate Period is October 1,1998 to September 30, 1999

Capitation Payments at the Beginning of the Month

Coverages

Coverage	Status
CCS Indicated Claims	NOT Covered by the Plan
Mental Health Outpatient Services	NOT Covered by the Plan
Mental Health Pharmacy Costs	NOT Covered by the Plan
Mental Health Hospital Inpatient Services	NOT Covered by the Plan
Eyewear	NOT Covered by the Plan
Heroin Detoxification	NOT Covered by the Plan
AIDS Waiver Services	NOT Covered by the Plan
Adult Day Health Care	NOT Covered by the Plan
Chiropractor/Acupuncture	NOT Covered by the Plan
Local Education Authority	NOT Covered by the Plan
Alphateto Protein Testing	NOT Covered by the Plan
Long Term Care for month of entry plus one	Covered-by the Plan
Long Term Care after month of entry plus one	NOT Covered by the Plan
Special AIDS drugs	NOT Covered by the Plan

C5 to Contract 95-23637
Attachment 1

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care
1. Average Cost Per Unit	$ 90.48	$ 17.11	$ 964.66	$ 15.76	$ 812.04
2. Units per Eligible	21.383	5.818	5.446	4.679	0.000
3. Addt'l Capitation Amts.	$ 0.37	$ 0.06	$ 35.62	$ 0.08	$ 0.00
Cost per Elig. per Mo.	$ 161.60	$ 8.36	$ 473.41	$ 6.23	$ 0.00
Adjustments					
a. Demographics	1.000	1.000	1.000	1.000	1.000
b. Area	1.043	1.000	1.000	1.000	1.000
c. Coverages	0.999	0.999	0.999	0.989	1.000
d. Interest	0.995	0.995	0.995	0.995	0.995
Adjusted Base Cost	$ 167.54	$ 8.31	$ 470.57	$ 6.13	$ 0.00
3. Legislative Adjs.	1.029	1.054	1.000	1.022	1.102
4. Trend Adjustments					
a. Cost per Unit	1.000	1.100	1.050	1.000	1.000
b. Units per Eligible	0.950	1.000	1.050	0.950	1.050
Projected Cost per Eligible	$ 163.76	$ 9.63	$ 518.80	$ 5.95	$ 0.00
5. Stop Loss Reins	Amount		$ 0		
6. CHDP					
7. Fee-for-Service Adj.					
Capitation Rale With FQHC Increment		$ 706.77 / Without		$ 705.26	

Rate Calculation		Other	FFSE	FQHC Increment	Total
1. Average Cost Per Unit		$ 36.13	$ 66.39	$ 24.41	
2. Units per Eligible		10.172	0.735	0.735	
3. Addt'l Capitation Amts.		$ 0.00	$ 0.00	$ 0.00	
Cost per Elig. per Mo.		$ 30.63	$ 4.19	$ 1.50	$ 685.92
Adjustments					
a. Demographics		1.000	1.000	1.000	
b. Area		1.000	1.000	1.000	
c. Coverages		0.809	0.995	0.995	
d. Interest		0.995	0.995	0.995	
Adjusted Base Cost		$ 24.66	$ 4.15	$ 1.49	$ 682.85
3. Legislative Adjs		1.004	1.015	1.015	
4. Trend Adjustments					
a. Cost per Unit		0.950	1.000	1.000	
b. Units per Eligible		1.050	1.000	1.000	
Projected Cost per Eligible		$ 24.70	$ 4.21	$ 1.51	$ 728.58
5. Stop Loss Reins	Rate	0.0%	Premium		0.00
6. CHDP					0.00
7. Fee-for-Service Adj.		-3.0%			(21.81)
Capitation Rate With FQHC Increment					

Plan Name: Molina Medical Center Plan#: 355 Date: 04-May-OO
County: Riverside Plan Type: Commercial Plan Base Period: FY 96/97
Ald Code Grouping: AIDS

The Rate Period Is October 1,1998 to September 3D, 1999

Capitation Payments at the Beginning of the Month

Coverages

Coverage	Status
CCS Indicated Claims	NOT Covered by the Plan
Mental Health Outpatient Services	NOT Covered by the Plan
Mental Health Pharmacy Costs	NOT Covered by the Plan
Mental Health Hospital Inpatient Services	NOT Covered by the Plan
Eyewear	NOT Covered by the Plan
Heroin Detoxification	NOT Covered by the Plan
AIDS Waiver Services	NOT Covered by the Plan
Adult Day Health Care	NOT Covered by the Plan
Chiropractor/Acupuncture	NOT Covered by the Plan
Local Education Authority	NOT Covered by the Plan
Alphateto Protein Testing	NOT Covered by the Plan
Long Term Care for month of entry plus one	Covered-by the Plan
Long Term Care after month of entry plus one	NOT Covered by the Plan
Special AIDS drugs	NOT Covered by the Plan

C5 to Contract 95-23637
Attachment 1

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care
1. Average Cost Per Unit	$ 32.67	$ 126.04	$ 485.15	$ 13.79	$ 139.87
2. Units per Eligible	26.305	74.792	3.169	9.882	0.000
3. Addt'l Capitation Amts	$ 2.96	$ 0.09	$ 9.89	$ 0.02	$ 0.00
Cost per Ellg. per Mo	$ 74.57	$ 785.66	$ 138.01	$ 11.38	$ 0.00
Adjustments					
a. Demographics	1.000	1.000	1.000	1.000	1.000
b. Area	1.043	1.000	1.000	1.000	1.000
c. Coverages	0.918	0.648	0.957	0.992	0.998
d. Interest	0.995	0.995	0.995	0.995	0.995
Adjusted Base Cost	$ 71.04	$ 506.56	$ 131.42	$ 11.23	$ 0.00
3. Legislative Adjs	0.963	1.006	0.977	0.982	1.186
4. Trend Adjustments					
a. Cost per Unit	1.000	1.100	1.050	1.000	1.100
b. Units per Eligible	1.100	1.210	1.050	1.045	0.950
Projected Cost per Eligible	$ 75.25	$ 678.28	$ 141.56	$ 11.52	$ 0.00
5. Slop Loss Reins	Amount		$ 0		
6. CHDP					
7. Fee-for-Service Adj.					
Capitation Rale With FQHC Increment		$ 962.42 / Without		$ 962.42	

Rate Calculation	Other	FFSE	FQHC Increment	Total
1. Average Cost Per Unit	$ 42.30	$ 66.52	$ 0.00	
2. Units per Eligible	36.392	0.628	0.628	
3. Addt'l Capitation Amts	$ 0.00	$ 0.00	$ 0.00	
Cost per Ellg. per Mo	$ 128.28	$ 3.48	$ 0.00	$ 1.141.30
Adjustments				
a. Demographics	1.000	1.000	1.000	
b. Area	1.000	1.000	1.000	
c. Coverages	0.599	0.951	0.951	
d. Interest	0.995	0.995	0.995	
Adjusted Base Cost	$ 76.46	$ 3.29	$ 0.00	$ 800.00
3. Legislative Adjs	0.979	0.984	0.984	
4. Trend Adjustments				
a. Cost per Unit	1.100	1.000	1.000	
b. Units per Eligible	1.000	1.000	1.000	
Projected Cost per Eligible	$ 82.34	$ 3.24	$ 0.00	$ 992.19
5. Slop Loss Reins	Rate 0,0%		Premium	0.00
6. CHDP				0.04
7. Fee-for-Service Adj.	-3.0%			(29.77)
Capitation Rale With FQHC Increment				

Aid Group Poverty-7A

Base: Statewide Family Age Adjusted
Base Period: FY 96/97

Payments at Beginning of Month

Services ==>	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Nursing Facility	Other	FFSE	FQHC Increment	Totals
1. Base Cost	$ 10.40	$ 6.74	$ 13.64	$ 3.91	$ 0.24	$ 8.30	$ 2.98	$ 1.21	$ 47.42
2. Age/5ex Adjustments	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	
3. Eligibility Adjustments	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	
4. Coverage Adjustments	0.997	0.997	0.999	0.964	1.000	0.891	0.991	0.991	
5. Interest Offset	0.990	0.996	0.987	0.989	0.993	0.990	0.994	0.994	
Contract Cost FY 96/37	$ 10.27	$ 6.69	$ 13.45	$ 3.73	$ 0.24	$ 7.32	$ 2.93	$ 1.20	$ 45.83
6. Legislative Adjustments	1.044	0.740	0.985	1.021	1.061	1.150	1.024	1.024	
7. Trend Adjustments									
a. Cost per Unit	1.000	1.308	1.055	0.970	1.000	1.445	1.071	1.071	
b. Utilization	1.000	1.027	1.050	1.000	1.107	1.000	1.265	1.265	
Projected Cost 10/98-9/99	$ 10.72	$ 6.65	$ 14.68	$ 3.69	$ 0.28	$ 12.16	$ 4.06	$ 1.66	$ 53.90
8.CHDP									$ 2.54
9. Administrative Allowance						1.6%			$ 0.88
Fee-for-Service Equivalent Cost									$ 57.32
Fee-for-Service Adj.						94%			(3.44)
Capitation Rate with FQHC Increment									$ 53.88
Capitation Rate without FQHC Increment									$ 52.32

Aid Group Poverty-47/72 Base: Statewide
Base Period: FY 96/97

Payments at Beginning of Month

Services ==>	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Nursing Facility	Other	FFSE	FQHC Increment	Totals
1. Base Cost	$ 10.66	$ 7.27	$ 20.52	$ 5.31	$ 0.14	$ 2.92	$ 5.42	$ 2.21	$ 54.45
2. Age/5ex Adjustments	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	
3. Eligibility Adjustments	1.000	1.000	1.000	1,000	1.000	1.000	1.000	1.000	
4. Coverage Adjustments	0.997	0.997	0.999	0.964	1.000	0.891	0.991	0.991	
5. Interest Offset	0.990	0.996	0.987.	0.989	0.993	0.990	0.994	0.994	
Contract Cost FY 96/37	$ 10.52	$ 7.22	$ 20.24	$ 5.07	$ 0.14	$ 2.57	$ 5.34	$ 2.18	$ 53.28
6. Legislative Adjustments	1.044	0.740	0.985	1.021	1.061	1.150	1.024	1.024	
7. Trend Adjustments									
a. Cost per Unit	1.000	1.308	1.055	0.970	1.000	1.445	1.071	1.071	
b. Utilization	1.000	1.027	1.050	1.000	1.107	1.000	1.265	1.265	
Projected Cost 10/98-9/99	$ 10.98	$ 7.18	$ 22.08	$ 5.02	$ 0.16	$ 4.27	$ 7.41	$ 3.02	$ 60.12
8.CHOP									$ 2.54
9. Administrative Allowance						1.6%			$ 0.95
Fee-for-Service Equivalent Cost									$ 63.61
Fee-for-Service Adj.						94%			(3.82)
Capitation Rate with FQHC Increment									$ 59.79
Capitation Rate without FQHC Increment									$ 56.95

Plan Name:	Molina Medical Center	Plan#:	356	Date:	01-Dec-99
County:	San Bernardino	Plan Type:	Commercial Plan	Base Period:	FY 96/97
Ald Code Grouping:	Family				

The Rate Period Is October 1,1998 to September 3D, 1999

Capitation Payments at the Beginning of the Month

Coverages

Coverage	Status
CCS Indicated Claims	NOT Covered by the Plan
Mental Health Outpatient Services	NOT Covered by the Plan
Mental Health Pharmacy Costs	NOT Covered by the Plan
Mental Health Hospital Inpatient Services	NOT Covered by the Plan
Eyewear	NOT Covered by the Plan
Heroin Detoxification	NOT Covered by the Plan
AIDS Waiver Services	NOT Covered by the Plan
Adult Day Health Care	NOT Covered by the Plan
Chiropractor/Acupuncture	NOT Covered by the Plan
Local Education Authority	NOT Covered by the Plan
Alphateto Protein Testing	NOT Covered by the Plan
Long Term Care for month of entry plus one	Covered-by the Plan
Long Term Care after month of entry plus one	NOT Covered by the Plan
Special AIDS drugs	NOT Covered by the Plan

C5 to Contract 95-23637
Attachment 1

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care
1. Average Cost Per Unit	$ 69.46	$ 19.88	$ 978.02	$ 16.16	$ 812.04
2. Units per Eligible	4.050	4.683	0.373	2.146	0.004
3. Add'l Capitation Amis	$ 0.37	$0.05	$ 4.62	$ 0.01	$ 0.00
Cost per Ellg. per Mo	$ 23.81	$ 7.81	$ 35.02	$ 2.90	$ 0.27
Adjustments					
a. Demographics	0.997	0.993	0.977	0.987	1.000
b. Area	1.043	1.000	1.000	1.000	1.000
c. Coverages	0.975	0.992	0.968	0.956	0.995
d. Interest	1.000	1.000	1.000	1.000	1.000
Adjusted Base Cost	$ 24.14	$ 7.69	$ 33.12	$ 2.74	$ 0.27
3. Legislative Adjs,	1.053	1.053	0.998	1.023	1.141
4. Trend Adjustments					
a. Cost per Unit	1.000	1.100	1.050	1.000	1.000
b. Units per Eligible	0.950	1.000	1.050	0.950	1.050
Projected Cost per Eligible	$ 24.15	$ 8.91	$ 36.44	$ 2.66	$ 0.32
5. Slop Loss Reins		Amount	$ 0		
6. CHOP					
7. Fee-for-Sarvice Adj.					
Capitation Rate With FQHC Increment		$ 80.89 /Without		$80.82	

Rate Calculation		FQHC Other	FFSE	Increment	Total
1. Average Cost Per Unit		$ 20.09	$ 68.10	$ 7.33	
2. Units per Eligible		3.532	0.132	0.132	
3. Add'l Capitation Amis		$ 0.00	$ 0.00	$ 0.00	
Cost per Ellg. per Mo		$5.91	$ 0.75	$ 0.08	$ 76.55
Adjustments					
a. Demographics		0.985	0.992	0.992	
b. Area		1.000	1.000	1.000	
c. Coverages		0.833	0.935	0.935	
d. Interest		1.000	1.000	1.000	
Adjusted Base Cost		$ 4.85	$ 0.70	$ 0.07	$ 73.58
3. Legislative Adjs,		1.046	1.027	1.027	
4. Trend Adjustments					
a. Cost per Unit		0.950	1.000	1.000	
b. Units per Eligible		1.050	1.000	1.000	
Projected Cost per Eligible		$ 5.06	$ 0.72	$ 0.07	$ 78.33
5. Slop Loss Reins	Rate	0,0%	Premium		0.00
6. CHOP					5.06
7. Fee-for-Sarvice Adj.		-3.0%			(2.50)

Plan Name:	Molina Medical Center	Plan#:	356	Date:	01-Dec-99
County:	San Bernardino	Plan Type:	Commercial Plan	Base Period:	FY 96/97
Ald Code Grouping:	Disabled				

The Rate Period Is October 1,1998 to September 30, 1999

Capitation Payments at the Beginning of the Month

Coverages

Coverage	Status
CCS Indicated Claims	NOT Covered by the Plan
Mental Health Outpatient Services	NOT Covered by the Plan
Mental Health Pharmacy Costs	NOT Covered by the Plan
Mental Health Hospital Inpatient Services	NOT Covered by the Plan
Eyewear	NOT Covered by the Plan
Heroin Detoxification	NOT Covered by the Plan
AIDS Waiver Services	NOT Covered by the Plan
Adult Day Health Care	NOT Covered by the Plan
Chiropractor/Acupuncture	NOT Covered by the Plan
Local Education Authority	NOT Covered by the Plan
Alphateto Protein Testing	NOT Covered by the Plan
Long Term Care for month of entry plus one	Covered-by the Plan
Long Term Care after month of entry plus one	NOT Covered by the Plan
Special AIDS drugs	NOT Covered by the Plan

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care
1. Average Cost Per Unit	$ 46.41	$ 39.70	$ 611.26	$ 12.37	$ 139.87
2. Units per Eligible	6.969	26.661	1.556	5.050	0.459
3. Addt'l Capitation Amts	$ 2.96	$ 0.09	$ 9.89	$ 0.02	$ 0.00
Cost per Ellg. per Mo	$ 29.91	$ 88.45	$ 89.15	$ 5.23	$ 5.35
Adjustments					
a. Demographics	0.980	0.973	0.961	0.998	0.996
b. Area	1.043	1.000	1.000	1.000	1.000
c. Coverages	0.900	0.875	0.920	0.973	0.995
d. Interest	1.000	1.000	1.000	1.000	1.000
Adjusted Base Cost	$ 27.51	$ 75.74	$ 78.82	$ 5.08	$ 5.30
3. Legislative Adjs	0.941	1.043	0.919	0.931	1.130
4. Trend Adjustments					
a. Cost per Unit	1.000	1.100	1.050	1.000	1.100
b. Units per Eligible	1.100	1.210	1.050	1.045	0.950
Projected Cost per Eligible	$ 28.48	$ 105.14	$ 79.86	$ 4.94	$ 6.26
5. Slop Loss Reins	Amount		$ 0		
6. CHDP					
7. Fee-for-Service Adj.					
Capitation Rale With FQHC Increment		$ 234.65 / Without		$ 234.65	

Rate Calculation		Other	FQHC FFSE	Increment	Total
1. Average Cost Per Unit		$ 10.16	$ 69.96	$ 0.00	
2. Units per Eligible		21.959	0.120	0.120	
3. Addt'l Capitation Amts		$ 0.00	$ 0.00	$ 0.00	
Cost per Ellg. per Mo		$ 18.59	$ 0.70	0.00	$ 237.89
Adjustments					
a. Demographics		1.006	0.989	0.989	
b. Area		1.000	1.000	1.000	
c. Coverages		0.878	0.863	0.863	
d. Interest		1.000	1.000	1.000	
Adjusted Base Cost		$ 16.42	$ 0.60	$ 0.00	$ 209.47
3. Legislative Adjs		0.923	0.932	0.932	
4. Trend Adjustments					
a. Cost per Unit		1.100	1.000	1,000	
b. Units per Eligible		1.000	1.000	1.000	
Projected Cost per Eligible		$ 16.67	$ 0.56	$ 0.00	$ 241.91
5. Slop Loss Reins	Rate	0.0%	Premium		0.00
6. CHDP					0.00
7. Fee-for-Service Adj.		-3.0%			(7.26)
Capitation Rale With FQHC Increment					

Plan Name: Molina Medical Center   Plan#: 356   Date: 01-Dec-99
County: San Bernardino   Plan Type: Commercial Plan   Base Period: FY 96/97
Ald Code Grouping: Aged

The Rate Period Is October 1,1998 to September 3D, 1999

Capitation Payments at the Beginning of the Month

Coverages

CCS Indicated Claims	NOT Covered by the Plan
Mental Health Outpatient Services	NOT Covered by the Plan
Mental Health Pharmacy Costs	NOT Covered by the Plan
Mental Health Hospital Inpatient Services	NOT Covered by the Plan
Eyewear	NOT Covered by the Plan
Heroin Detoxification	NOT Covered by the Plan
AIDS Waiver Services	NOT Covered by the Plan
Adult Day Health Care	NOT Covered by the Plan
Chiropractor/Acupuncture	NOT Covered by the Plan
Local Education Authority	NOT Covered by the Plan
Alphateto Protein Testing	NOT Covered by the Plan
Long Term Care for month of entry plus one	Covered-by the Plan
Long Term Care after month of entry plus one	NOT Covered by the Plan
Special AIDS drugs	NOT Covered by the Plan

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care
1. Average Cost Per Unit	$ 48.90	$ 32.71	$ 316.16	$ 10.02	$ 77.33
2. Units per Eligible	4.580	21.914	1.265	3.306	2.016
3. Add'l Capitation Amts	$ 1.29	$ 0.00	$ 7.41	$ 0.02	$ 0.00
Cost per Ellg. per Mo	$ 19.95	$ 59.73	$ 40.74	$ 2.78	$ 12.99
Adjustments					
a. Demographics	0.963	1.014	0.962	0.975	1.027
b. Area	1.043	1.000	1.000	1.000	1.000
c. Coverages	0.981	0.996	0.997	0.986	0.997
d. Interest	1.000	1.000	1.000	1.000	1.000
Adjusted Base Cost	$ 19.66	$ 60.32	$ 39.07	$ 2.67	$ 13.30
3. Legislative Adjs	0.939	1.049	0.926	0.931	1.140
4. Trend Adjustments					
a. Cost per Unit	1.100	1.100	1.100	1.050	1.000
b. Units per Eligible	1.100	1.155	1.100	1.100	1.000
Projected Cost per Eligible	$ 22.34	$ 80.39	$ 43.78	$ 2.87	$ 15.16
5. Stop Loss Reins		Amount	$ 0		
6. CHOP					
7. Fee-for-Service Adj.					
Capitation Rate With FQHC Increment		$ 164.60 /Without		$ 164.60	

Rate Calculation		Other	FQHC FFSE	Increment	Total
1. Average Cost Per Unit		$ 6.41	$ 50.63	$ 0.00	
2. Units per Eligible		12.862	0.024	0.024	
3. Add'l Capitation Amts		$ 0.00	$ 0.00	$ 0.00	
Cost per Ellg. per Mo		$ 6.87	$ 0.10	$ 0.00	$ 143.16
Adjustments					
a. Demographics		1.013	0.979	0.979	
b. Area		1.000	1.000	1.000	
c. Coverages		0.791	0.603	0.603	
d. Interest		1.000	1.000	1.000	
Adjusted Base Cost		$ 5.50	$ 0.06	$ 0.00	$ 140.58
3. Legislative Adjs		0.927	0.926	0.926	
4. Trend Adjustments					
a. Cost per Unit		1.050	1.000	1.000	
b. Units per Eligible		0.950	1.000	1.000	
Projected Cost per Eligible		$ 5.09	$ 0.06	$ 0.00	$ 169.69
5. Stop Loss Reins	Rate	0.0%	Premium		0.00
6. CHOP					0.00
7. Fee-for-Service Adj.		-3.0%			(5.09)
Capitation Rate With FQHC Increment					

Plan Name: Molina Medical Center Plan#: 356 Date: 01-Dec-99
County: San Bernardino Plan Type: Commercial Plan Base Period: FY 96/97
Ald Code Grouping: Child

The Rate Period Is October 1,1998 to September 3D, 1999

Capitation Payments at the Beginning of the Month

Coverages

CCS Indicated Claims	NOT Covered by the Plan
Mental Health Outpatient Services	NOT Covered by the Plan
Mental Health Pharmacy Costs	NOT Covered by the Plan
Mental Health Hospital Inpatient Services	NOT Covered by the Plan
Eyewear	NOT Covered by the Plan
Heroin Detoxification	NOT Covered by the Plan
AIDS Waiver Services	NOT Covered by the Plan
Adult Day Health Care	NOT Covered by the Plan
Chiropractor/Acupuncture	NOT Covered by the Plan
Local Education Authority	NOT Covered by the Plan
Alphateto Protein Testing	NOT Covered by the Plan
Long Term Care for month of entry plus one	Covered-by the Plan
Long Term Care after month of entry plus one	NOT Covered by the Plan
Special AIDS drugs	NOT Covered by the Plan

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care
1. Average Cost Per Unit	$ 67.42	$ 13.64	$ 1,120.53	$ 16.21	$ 469.38
2. Units per Eligible	4.035	3.411	0.465	1.516	0.007
3. Add'l Capitation Amts	$ 0.23	$ 0.03	$ 2.90	$ 0.00	$ 0.00
Cost par Ellg. per Mo	$ 22.90	$ 3.91	$ 46.32	$ 2.05	$ 0.27
Adjustments					
a. Demographics	1.212	1.021	1.342	1.157	1.000
b. Area	1.043	1.000	1.000	1.000	1.000
c. Coverages	0.974	0.984	0.952	0.973	0.996
d. Interest	1.000	1.000	1.000	1.000	1.000
Adjusted Base Cost	$ 28.20	$ 3.93	$ 59.18	$ 2.31	$ 0.27
3. Legislative Adjs	1.076	1.047	0.999	1.024	1.134
4. Trend Adjustments					
a. Cost per Unit	1.000	1.100	1.050	1.000	1.000
b. Units per Eligible	0.950	1.000	1.050	0.950	1.050
Projected Cost per Eligible	$ 28.83	$ 4.53	$ 65.18	$ 2.25	$ 0.32
5. Stop Loss Reins	Amount		$ 0		Rate
6. CHOP					
7. Fee-for-Service AdJ.					

Capitation Rate With FQHC Increment $ 106.97 /Without $ 106.89

Rate Calculation	Other	FQHC FFSE	Increment	Total
1. Average Cost Per Unit	$ 20.69	$ 68.10	$ 7.33	
2. Units per Eligible	1.958	0.132	0.132	
3. Add'l Capitation Amts	$ 0.00	$ 0.00	$ 0.00	
Cost par Ellg. per Mo	$ 3.38	$ 0.75	$ 0.08	$ 79.66
Adjustments				
a. Demographics	1.080	1.084	1.084	
b. Area	1.000	1.000	1.000	
c. Coverages	0.815	0.970	0.970	
d. Interest	1.000	1.000	1.000	
Adjusted Base Cost	$ 2.98	$ 0.79	$ 0.08	$ 97.74
3. Legislative Adjs	1.090	1.031	1.031	
4. Trend Adjustments				
a. Cost per Unit	0.950	1.000	1.000	
b. Units per Eligible	1.050	1.000	1.000	
Projected Cost per Eligible	$ 3.24	$ 0.81	$ 0.08	$ 105.24
5. Stop Loss Reins			Premium	0.00
6. CHDP				5.04
7. Fee-for-Service AdJ.	-3.0%			(3.31)
Capitation Rate With FQHC Increment				

Plan Name: Molina Medical Center   Plan#: 356   Date: 01-Dec-99
County: San Bernardino   Plan Type: Commercial Plan   Base Period: FY 96/97
Ald Code Grouping: Adult

The Rate Period Is October 1,1998 to September 3D, 1999

Capitation Payments at the Beginning of the Month

Coverages

CCS Indicated Claims	NOT Covered by the Plan
Mental Health Outpatient Services	NOT Covered by the Plan
Mental Health Pharmacy Costs	NOT Covered by the Plan
Mental Health Hospital Inpatient Services	NOT Covered by the Plan
Eyewear	NOT Covered by the Plan
Heroin Detoxification	NOT Covered by the Plan
AIDS Waiver Services	NOT Covered by the Plan
Adult Day Health Care	NOT Covered by the Plan
Chiropractor/Acupuncture	NOT Covered by the Plan
Local Education Authority	NOT Covered by the Plan
Alphateto Protein Testing	NOT Covered by the Plan
Long Term Care for month of entry plus one	Covered-by the Plan
Long Term Care after month of entry plus one	NOT Covered by the Plan
Special AIDS drugs	NOT Covered by the Plan

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care
1. Average Cost Per Unit	$ 90.48	$ 17.11	$ 1,140.81	$ 15.76	$ 812.04
2. Units per Eligible	21.541	5.818	5.446	4.679	0.000
3. Add'l Capitation Amts	$ 0.37	$ 0.06	$ 35.62	$ 0.08	$ 0.00
Cost per Ellg. per Mo	$ 162.79	$ 6.36	$ 553.36	$ 6.23	$ 0.00
Adjustments					
a. Demographics	1.000	1.000	1.000	1.000	1.000
b. Area	1.043	1.000	1.000	1.000	1.000
c. Coverages	0.999	0.999	0.999	0.989	1.000
d. Interest	1.000	1.000	1.000	1.000	1.000
Adjusted Base Cost	$ 169.62	$ 8.35	$ 552.81	$ 6.16	$ 0.00
3. Legislative Adjs	1.029	1.054	1.000	1.022	1.102
4. Trend Adjustments					
a. Cost per Unit	1.000	1.100	1.050	1.000	1.000
b. Units per Eligible	0.950	1.000	1.050	0.950	1.050
Projected Cost per Eligible	$ 165.81	$ 9.68	$ 609.47	$ 5.98	$ 0.00
5. Stop Loss Reins		Amount	$ 0		
6. CHOP					
7. Fee-for-Service Adj.					

Capitation Rate With FQHC Increment $ 794.86 /Without $ 794.50

Rate Calculation	Other	FQHC FFSE	Increment	Total
1. Average Cost Per Unit	$ 36.13	$ 68.10	$ 7.33	
2. Units per Eligible	10.172	0.577	0.577	
3. Add'l Capitation Amts	$ 0.00	$ 0.00	$ 0.00	
Cost par Ellg. per Mo	$ 30.63	$ 3.28	$ 0.35	$ 765.00
Adjustments				
a. Demographics	.	1.000	1.000	
b. Area	1.000	1.000	1.000	
c. Coverages	0.809	0.995	.0.995	
d. Interest	1.000	1.000	1.000	
Adjusted Base Cost	$ 24.78	$ 3.26	$ 0.35	$ 765.33
3. Legislative Adjs	1.004	1.015	1.015	
4. Trend Adjustments				
a. Cost per Unit	0.950	1.000	1.000	
b. Units per Eligible	1.050	1.000	1.000	
Projected Cost per Eligible	$ 24.82	$ 3.31	$ 0.36	$ 819.43
5. Stop Loss Reins	0.0%		Premium	0.00
6. CHOP				0.00
7. Fee-for-Service Adj.	-3.0%			(24.57)
Capitation Rate With FQHC Increment				

Plan Name:	Molina Medical Center	Plan#: 356	Date:	01-Dec-99
County:	San Bernardino	Plan Type: Commercial Plan	Base Period:	FY 96/97
Ald Code Grouping:	AIDS			

The Rate Period Is October 1,1998
to September 3D, 1999

Capitation Payments at the
Beginning of the Month

Coverages

Coverage	Status
CCS Indicated Claims	NOT Covered by the Plan
Mental Health Outpatient Services	NOT Covered by the Plan
Mental Health Pharmacy Costs	NOT Covered by the Plan
Mental Health Hospital Inpatient Services	NOT Covered by the Plan
Eyewear	NOT Covered by the Plan
Heroin Detoxification	NOT Covered by the Plan
AIDS Waiver Services	NOT Covered by the Plan
Adult Day Health Care	NOT Covered by the Plan
Chiropractor/Acupuncture	NOT Covered by the Plan
Local Education Authority	NOT Covered by the Plan
Alphateto Protein Testing	NOT Covered by the Plan
Long Term Care for month of entry plus one	Covered-by the Plan
Long Term Care after month of entry plus one	NOT Covered by the Plan
Special AIDS drugs	NOT Covered by the Plan

C5 to Contract 95-23637
Attachment 1

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care
1. Average Cost Per Unit	$ 32.67	$ 126.04	$ 611.26	$ 13.79	$ 139.87
2. Units per Eligible	26.584	74.792	3.169	9.882	0.000
3. Add'l Capitation Amis	$ 2.96	$ 0.09	$ 9.89	$ 0.02	$ 0.00
Cost per Elig. per Mo	$ 75.33	$ 785.66	$ 171.31	$ 11.38	$ 0.00
Adjustments					
a. Demographics	1.000	1.000	1.000	1.000	1.000
b. Area	1.043	1.000	1.000	1.000	1.000
c. Coverages	0.918	0.648	0.957	0.992	0.998
d. Interest	1.000	1.000	1.000	1.000	1.000
Adjusted Base Cost	$ 72.13	$ 509.11	$ 163.94	$ 11.29	$ 0.00
3. Legislative Adjs	0.963	1.006	0.977	0.982	1.186
4. Trend Adjustments					
a. Cost per Unit	1.000	1.100	1.050	1.000	1,100
b. Units per Eligible	1.100	1.210	1.050	1.045	0.950
Projected Cost per Eligible	$ 76.41	$ 681.69	$ 176.59	$ 11.59	$ 0.00
5. Stop Loss Reins					
6. CHOP					
7. Fee-for-Service Adj.					

Capitation Rate With FQHC Increment $ 1,000.01/Without $ 1,000.01

Rate Calculation	Other	FQHC FFSE	Increment	Total
1. Average Cost Per Unit	$ 42.30	$ 69.96	$ 0.00	
2. Units per Eligible	36.392	0.349	0.349	
3. Add'l Capitation Amis	$ 0.00	$ 0.00	$ 0.00	
Cost per Elig. per Mo	$ 128.28	$ 2.04	$ 0.00	$ 1,174.00
Adjustments				
a. Demographics	1.000	1.000	1.000	
b. Area	1.000	1.000	1.000	
c. Coverages	0.599	0.951	0.951	
d. Interest	1.000	1.000	1,000	
Adjusted Base Cost	$ 76.84	$ 1.94	$ 0.00	$ 835.25
3. Legislative Adjs	0.979	0.984	0.984	
4. Trend Adjustments				
a. Cost per Unit	1.100	1,000	1.000	
b. Units per Eligible	1.000	1.000	1.000	

Projected Cost per Eligible		$ 82.75	$ 1.91	$ 0.00		$ 1,030.94
5. Stop Loss Reins		0.0%				0.00
6. CHOP						0.00
7. Fee-for-Service Adj.	Rate	-3.0%			Premium	(30.93)
Capitation Rate With FQHC Increment						

Aid Group Poverty-47/72

Base: Statewide
Base Period: FY 96/97

Payments at Beginning of Month
Services ==>

	physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Nursing Facility	Other	FFSE	FQHC Increment	Totals
1. Base Cost	$ 10.40	$ 6.74	$ 13.64	$ 3.91	$ 0.24	$ 8.30	$ 2.96	$ 1.21	$ 47.42
2. Age/5ex Adjustments	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	
3. Eligibility Adjustments	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	
4. Coverage Adjustments	0.997	0.997	0.999	0.964	1.000	0.891	0.991	0.991	
5. Interest Offset	0.995	1.001	0.991	0.993	0.998	0.995	0.998	0.998	
Contract Cost FY 96/37	$ 10.32	$ 6.73	$ 13.50	$ 3.74	$ 0.24	$ 7.36	$ 2.94	$ 1.20	$ 46.03
6. Legislative Adjustments	1.044	0.740	0.985	1.021	1.061	1.150	1.024	1.024	
7. Trend Adjustments									
a. Cost per Unit	1.000	1.308	1.055	0.970	1.000	1.445	1.071	1.071	
b. Utilization	1.000	1.027	1.050	1.000	1.107	1.000	1.265	1.265	
Projected Cost 10/98-9/99	$ 10.77	$ 6.69	$ 14.73	$ 3.70	$ 0.28	$ 12.23	$ 4.08	$ 1.66	$ 54.14
8.CHOP									$ 2.54
9. Administrative Allowance						1.5%			$ 0.88
Fee-for-Service Equivalent Cost									$ 57.56
Fee-for-Service Adj.						94%			(3.45)
Capitation Rate with FQHC Increment									$ 54.11
Capitation Rate without FQHC Increment									$ 52.55

Aid Group Poverty-47/72

Base: Statewide
Base Period: FY 96/97

Payments at Beginning of Month
Services ==>

	physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Nursing Facility	Other	FFSE	FQHC Increment	Totals
1. Base Cost	$ 10.66	$ 7.27	$ 20.52	$ 5.31	$ 0.14	$ 2.92	$ 5.42	$ 2.21	$ 54.45
2. Age/5ex Adjustments	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	
3. Eligibility Adjustments	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	
4. Coverage Adjustments	0.997	0.997	0.999	0.964	1.000	0.891	0.991	0.991	
5. Interest Offset	0.995	1.001	0.991	0.993	0.998	0.995	0.998	0.994	
Contract Cost FY 96/37	$ 10.57	$ 7.25	$ 20.32	$ 5.09	$ 0.14	$ 2.59	$ 5.36	$ 2.18	$ 53.50
6. Legislative Adjustments	1.044	0.740	0.985	1.021	1.061	1.150	1.024	1.024	
7. Trend Adjustments									
a. Cost per Unit	1.000	1.308	1.055	0.970	1.000	1.445	1.071	1.071	
b. Utilization	1.000	1.027	1.050	1.000	1.107	1.000	1.265	1.265	
Projected Cost 10/98-9/99	$ 11.04	$ 7.21	$ 22.17	$ 5.04	$ 0.16	$ 4.30	$ 7.44	$ 3.02	$ 60.38
8.CHOP									$ 2.54
9. Administrative Allowance						1.5%			$ 0.96
Fee-for-Service Equivalent Cost									$ 63.88
Fee-for-Service Adj.						94%			(3.83)
Capitation Rate with FQHC Increment									$ 60.05
Capitation Rate without FQHC Increment									$ 57.21

STATE OF CALIFORNIA-HEALTH AND HUMAN SERVICES AGENCY GRAY DAVIS, Governor

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[SEAL OF DEPARTMENT OF HEALTH SERVICES]

[SEAL]

DEPARTMENT OF HEALTH SERVICES
714/744 P Street
P. O. Box 942732
Sacramento, CA 94234-7320
(916)654-8076

February 8, 2000

Mr. George Goldstein, President
Molina
One Golden Shore
Long Beach, CA 90802

Dear Mr. Goldstein:

In accordance with Article V, Section 5.5 of your Contract, the enclosed Change Order No. 06 transmits (Molina's) annual capitation rates for the period October 1, 1999 to September 30, 2000.

This Change Order also includes a rate change for the two-month period of August 1999 through September 1999, to include the provider rate increases established in the Budget Act of 1999/2000, which were effective August 1, 1999.

The retropayment between the old rates and the new 1999/2000 rates for the period October 1, 1999 through February 2000 and the provider rate increases for the period August 1999 through September 1999 will appear in your capitation check for February 2000. The March capitation check will reflect the 1999/2000 rates.

If you have any questions, please contact your contract manager.

Sincerely,

/s/
Susanne M. Hughes
Acting Chief
Medi-Cal Managed Care Division

STATE OF CALIFORNIA-HEALTH AND HUMAN SERVICES AGENCY GRAY DAVIS, Governor

[SEAL OF DEPARTMENT OF HEALTH SERVICES]

[SEAL]

DEPARTMENT OF HEALTH SERVICES
714/744 P Street
P. O. Box 942732
Sacramento, CA 94234-7320
(916)654-8076

CHANGE ORDER C06 TO CONTRACT NO.95-23637: ADJUSTING THE ANNUAL CAPITATION RATE FOR PROVIDER RATE INCREASES DURING THE TWO MONTH PERIOD OF AUGUST 1, 1999 THROUGH SEPTEMBER 30, 1999; AND THE ANNUAL CAPITATION RATES FOR THE PERIOD OCTOBER 1,1999 TO SEPTEMBER 30, 2000, BY CHANGING CONTRACT SECTIONS; 5.3 CAPITATION RATES; AND 5.4 CAPITATION RATES CONSTITUTE PAYMENT IN FULL. This Change Order is effective February 1, 2000.

1. 5.3 CAPITATION RATES

For the Period 8-1-99 to 9-30-99 San Bernardino County

GROUPS	AID CODES	RATE
Family	01, OA. 02, 08, 30, 32, 33, 34, 35, 38, 39, 40, 42, 54, 59, 3A, 3C, 3E, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 5X.7X	81.00
Disabled	20,24, 26, 28, 36, 60, 64, 66, 68, 6A, 6C, 6N, 6P, 6R	234.98
Aged	10, 14. 16. 18	165.06
Child	03, 04, 4C, 4K, 5K, 45,82	107.27
Adult	86	796.46
AIDS Beneficiary		996.35
Percent of Poverty	7A	52.87
Percent of Poverty	47,72	57.53

For the Period 8-1-99 to 9-30-99 Riverside County

GROUPS	AID CODES	RATE
Family	01, OA, 02, 08, 30, 32, 33, 34, 35, 38, 39, 40, 42, 54, 59, 3A, 3C, 3E, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, SX,7X	78.99
Disabled	20,24, 26, 28, 36, 60, 64, 66; 68, 6A, 6C, 6N, 6P. 6R	224.00
Aged	10, 14, 16, 18	161.75
Child	03, 04, 4C, 4K, 5K, 45,82	93.54
Adult	86	710.61
AIDS Beneficiary		963.67
Percent of Poverty	7A	52.87
Percent of Poverty	47,72	57.53

For the period 10-1-99 to 9-30-2000 San Bernardino County

GROUPS	AID CODES	RATE
Family	01. OA. 02, 08, 30, 32, 33, 34, 35, 38, 39, 40, 42, 54, 59, 3A, 3C, 3E, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 4F, 4G, 5X, 7A, 7X	84.07
Disabled	20, 24, 26, 28, 36, 60, 64, 66, 68, 6A, 6C, 6N, 6P, 6R	198.68
Aged	10, 14, 16, 18	145.52
Child	03, 04, 4A, AC, 4K, 5K, 45, 47, 72, 82, 8R.8P	8582
Adult	86	914.05
AIDS Beneficiary		763.69

Riverside County

For the period 10-1-99 to 9-30-2QQQ

GROUPS	AID CODES	RATE
Family	01, 0A, 02, 08, 30, 32, 33, 34, 35, 38, 39, 40, 42, 54, 59, 3A, 3C, 3E, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 4F, 4G, 5X, 7A, 7X	79.61
Disabled	20, 24. 26, 28, 36, GO, 64, 66, 68, 6A, 6C, 6N, 6P, 6R	201.02
Aged	10, 14, 16, 18	143.42
Child	03, 04, 4A, 4C, 4K, 5K, 45, 47, 72, 82, 8R.8P	101.31
Adult	86	838.60
AIDS Beneficiary		722.10

. Aid codes 4A, 4F, 4G, 8R, & 8P will be effective February 1, 2000.

. All other terms, conditions, and provisions contained in Section 5.3 remain unchanged.

2. 5.4 CAPITATION RATES CONSTITUTE PAYMENT IN FULL

Capitation rates for each rate period, as calculated by DHS, are prospective rates and constitute payment in full, subject to any stop loss reinsurance provisions, on behalf of a Member for all Covered Services required by such Member and for all Administrative Costs incurred by the Contractor in providing or arranging for such services, and subject to adjustments for federally qualified health centers in accordance with Section 14087.325 of the W&.I Code, but do not include payment for the recoupment of current or previous losses incurred by Contractor. DHS is not responsible for making payments for recoupment of losses. The actuarial basis for the determination of the capitation payment rates is outlined in Attachment 1 (consisting of 28 pages).

All other terms, conditions, and provisions contained in Section 5.4 remain unchanged.

Plan Name:	Molina Medical Center	Plan#:	356	Date:	01-Nov-99
County:	San Bernardino	Plan Type:	Commercial Plan	Base Period:	FY 96/97
Ald Code Grouping:	Family				

Adjusted Rate is Effective August 1, 1999 to September 30. 1999

Capitation Payments at the Beginning of the Month

Coverages

Coverage	Status
CCS Indicated Claims	NOT Covered by the Plan
Mental Health Outpatient Services	NOT Covered by the Plan
Mental Health Pharmacy Costs	NOT Covered by the Plan
Mental Health Hospital Inpatient Services	NOT Covered by the Plan
Eyewear	NOT Covered by the Plan
Heroin Detoxification	NOT Covered by the Plan
AIDS Waiver Services	NOT Covered by the Plan
Adult Day Health Care	NOT Covered by the Plan
Chiropractor/Acupuncture	NOT Covered by the Plan
Local Education Authority	NOT Covered by the Plan
Alphateto Protein Testing	NOT Covered by the Plan
Long Term Care for month of entry plus one	Covered by the Plan
Long Term Care after month of entry plus one	NOT Covered by the Plan
Special AIDS drugs	NOT Covered by the Plan

C6 to Contract 95-23637
Attachment 1

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care
1. Average Cost Per Unit	$ 69.46	$ 19.88	$ 978.02	$ 16.16	$ 812.04
2. Units per Eligible	4.050	4.683	0.373	2.146	0.004
3. Addt'l Capitation Amis	$ 0.37	$ 0.05	$ 4.62	$ 0.01	$ 0.00
Cost per Elig. per Mo	$ 23.81	$ 7.81	$ 35.02	$ 2.90	$ 0.27
4. Adjustments					
a. Demographics	0.997	0.993	0.977	0.987	1.000
b. Area	1.043	1.000	1.000	1.000	1.000
c. Coverages	0.975	0.992	0.968	0.956	0.995
d. Interest	0.995	0.995	0.995	0.995	0.995
Adjusted Base Cost	$ 24.02	$ 7.65	$ 32.95	$ 2.72	$ 0.27
5. Legislative Adjs	1.061	1.053	1.006	1.031	
6. Trend Adjustments					
a. Cost per Unit	1.000	1.100	1.050	1.000	1.000
b. Units per Eligible	0.950	1.000	1.050	0.950	1.050
Projected Cost per Eligible	$ 24.21	$ 8.86	$ 36.55	$ 2.66	$ 0.34
7. Stop Loss Reins.		Amount	$ 0		
8. CHOP					
9. Fee-for-Service Adj.					
Capitation Rate					

Rate Calculation	Other	FQHC FFSE	Increment	Total
1. Average Cost Per Unit	$ 20.09	$ 68.10		
2. Units per Eligible	3.532	0.132		
3. Addt'l Capitation Amis	$ 0.00	$ 0.00		
Cost per Elig. per Mo	$ 5.91	$ 0.75	$ 76.47	
4. Adjustments				
a. Demographics	0.985	0.992		
b. Area	1.000	1.000		
c. Coverages	0.833	0.935		
d. Interest	0.995	0.995		
Adjusted Base Cost	$ 4.82	$ 0.69	$ 73.12	
5. Legislative Adjs	1.061	1.041		
6. Trend Adjustments				
a. Cost per Unit	0.950	1.000		
b. Units per Eligible	1.050	1.000		
Projected Cost per Eligible	$ 5.10	$ 0.72	$ 78.44	
7. Stop Loss Reins.	Rate 0.0%		0.00	$ 78.44
8. CHOP				0.00
9. Fee-for-Service Adj.				5.06
Capitation Rate	-3.0%			(2.50)
				$ 81.00

Plan Name:	Molina Medical Center	Plant #: 356	Date:	16-NOV-99
County:	San Bernardino	Plan Type: Commercial Plan	Base Period:	FY 96/97
Aid Code Grouping:	Aged			

Adjusted Rate is Effective August 1,1999 to September 30, 1999

Capitation Payments at the Beginning of the Month

Coverages	
CCS Indicated Claims	NOT Covered by the Plan
Mental Health Outpatient Services	NOT Covered by the Plan
Mental Health Pharmacy Costs	NOT Covered by the Plan
Mental Health Hospital Inpatient Services	NOT Covered by the Plan
Eyewear	NOT Covered by the Plan
Heroin Detoxification	NOT Covered by the Plan
AIDS Waiver Services	NOT Covered by the Plan
Adult Day Health Care	NOT Covered by the Plan
Chiropractor/Acupuncture	NOT Covered by the Plan
Local Education Authority	NOT Covered by the Plan
Alphafeto Protein Testing	NOT Covered by the Plan
Long Term Care for month of entry plus one	Covered by the Plan
Long Term Care after month of entry plus one	NOT Covered by the Plan
Special AIDS drugs	NOT Covered by the Plan

C6 to Contract No. 95-23637

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	FQHC FFSE	Total
1. Average Cost Per Unit	$ 48.90	$ 32.71	$ 316.16	$ 10.02	$ 77.33	$ 6.41	$ 50.63	
2. Units per Eligible	4.580	21.914	1.265	3.306	2.016	12.862	0.024	
3. Addt'l Capitation Amis.	$ 1.29	$ 0.00	$ 7.41	$ 0.02	$ 0.00	$ 0.00	$ 0.00	
Cost per Elig. per Mo.	$ 19.95	$ 59.73	$ 40.74	$ 2.78	$ 12.99	$ 6.87	$ 0.10	$ 143.18
4. Adjustments								
a. Demographics	0.963	1.014	0.962	0.975	1.027	1.013	0.979	
b. Area	1.043	1.000	1.000	1.000	1.000	1.000	1.000	
c. Coverages	0.981	0.996	0.997	0.986	0.997	0.791	0.603	
d. Interest	0.995	O.995	0.995	0.995	0.995	0.995	0.995	
Adjusted Base Cost	$ 19.56	$ 60.02	$ 38.88	$ 2.66	$ 13.23	$ 5.48	$ 0.06	$ 139.89
5. Legislative Adjs.	0.947	1.049	0.933	0.939	1.194	0.941	0.939	
6. Trend Adjustments								
a.Cost per Unit	1.100	1.100	1.100	1.050	1.000	1.050	1.000	
b.Units per Eligible	1.100	1.155	1.100	1.100	1.000	0.950	1.000	
Projected Cost per Eligible	$ 22.41	$ 79.99	$ 43.89	$ 2.88	$ 15.80	$ 5.14	$ 0.06	$ 170.17
7. Stop Loss Reins.	Amount		$ 0	Rate		0.0%		0.00
8. CHOP								0.00
9. Fee-for-Service Adj.						-3.0%		(5.11)
Capitation Rate								$ 165.06

Department of Health Services, Rate Development Branch

Plan Name: Molina Medical Center | Plan#: 356 | Date: 16-Nov-99
Country: San Bernardino | Plan Type: Commercial Plan | Base Period: FY 96/97
Aid Code Grouping: Disabled

Adjusted Rate is Effective August 1, 1999 to September 30, 1999

Capitation Payments at the Beginning of the Month

Coverages

Coverage	Status
CCS Indicated Claims	NOT Covered by the Plan
Mental Health Outpatient Services	NOT Covered by the Plan
Mental Health Pharmacy Costs	NOT Covered by the Plan
Mental Health Hospital Inpatient Services	NOT Covered by the Plan
Eyewear	NOT Covered by the Plan
Heroin Detoxification	NOT Covered by the Plan
AIDS Waiver Services	NOT Covered by the Plan
Adult Day Health Cam	NOT Covered by the Plan
Chiropractor/Acupuncture	NOT Covered by the Plan
Local Education Authority	NOT Covered by the Plan
Alphafeto Protein Testing	NOT Covered by the Plan
Long Term Care for month of entry plus one	Covered by the Plan
Long Term Care after month of entry plus one	NOT Covered by the Plan
Special AIDS drugs	NOT Covered by the Plan

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Rate Calculation

	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	FQHC FFSE	Total
1. Average Cost Per Unit	$ 46.41	$ 39.70	$ 611.26	$ 12.37	$ 139.87	$ 10.16	$ 69.96	
2. Units per Eligible	6.969	26.861	1.556	5.050	0.459	21.959	0.120	
3. Addt'l Capitation Amts	$ 2.96	$ 0.09	$ 9.89	$ 0.02	$ 0.00	$0.00	$ 0.00	
Cost per Elig. per Mo.	$ 29.91	$ 88.96	$ 89.15	$ 5.23	$ 5.35	$ 18.59	$ 0.70	$ 237.89
4. Adjustments								
a. Demographics	0.980	0.973	0.961	0.998	0.996	1.006	0.989	
b. Area	1.043	1.000	1.000	1.000	1.000	1.000	1.000	
c. Coverages	0.900	0.875	0.920	0.973	0.995	0.878	0.863	
d. Interest	0.995	0.995	0,995	0.995	0.995	0.995	0.995	
Adjusted Base Cost	$ 27.38	$ 75.36	$ 78.43	$ 5.05	$ 5.28	$ 16.34	$ 0.59	$ 208.43
5. Legislative Adjs.	0.949	1.043	0.927	0.939	1.184	0.937	0.945	
6. Trend Adjustments								
a. Cost per Unit	1.000	1.100	1.050	1.000	1.100	1.100	1.000	
b. Units per Eligible	1.100	1.210	1.050	1.045	0.950	1.000	1.000	
Projected Cost per Eligible	$ 28.58	$ 104.62	$ 80.16	$ 4.96	$ 6.53	$ 16.84	$ 0.56	$ 242.25
7. Stop Loss Reins.	Amount		$ 0	Rate		0.0%		0.00
6. CHOP								0.00
9. Fee-for-Service Adj.						-3.0%		(7.27)
Capitation Rate								$ 234.98

Department of Health Services, Rate Development Branch

Plan Name: Molina Medical Center   Plan#: 356   Date: 16-Nov-99
Country: San Bernardino   Plan Type: Commercial Plan   Base Period: FY 96/97
Aid Code Grouping: Child

Adjusted Rate is Effective August 1, 1999 to September 30, 1999

Capitation Payments at the Beginning of the Month

Coverages

Coverage	Status
CCS Indicated Claims	NOT Covered by the Plan
Mental Health Outpatient Services	NOT Covered by the Plan
Mental Health Pharmacy Costs	NOT Covered by the Plan
Mental Health Hospital Inpatient Services	NOT Covered by the Plan
Eyewear	NOT Covered by the Plan
Heroin Detoxification	NOT Covered by the Plan
AIDS Waiver Services	NOT Covered by the Plan
Adult Day Health Care	NOT Covered by the Plan
Chiropractor/Acupuncture	NOT Covered by the Plan
Local Education Authority	NOT Covered by the Plan
Alphafeto Protein Testing	NOT Covered by the Plan
Long Term Care for month of entry plus one	Covered by the Plan
Long Term Care after month of entry plus one	NOT Covered by the Plan
Special AIDS drugs	NOT Covered by the Plan

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	FQHC FFSE	Total
1. Average Cost Per Unit	$ 67.42	$ 13.64	$ 1,120.53	$ 16.21	$ 469.38	$ 20.69	$ 68.10	
2. Units per Eligible	4.036	3.411	0.465	1.516	0.007	1.958	0.132	
3. Addt'l Capitation Amts	$ 0.23	$ 0.03	$ 2.90	$ 0.00	$ 0.00	$ 0.00	$ 0.00	
Cost per Elig. per Mo.	$ 22.90	$ 3.91	$ 46.32	$ 2.05	$ 0.27	$ 3.38	$ 0.75	$ 79.58
4. Adjustments								
a. Demographics	1.212	1.021	1.342	1.157	1.000	1.080	1.084	
b. Area	1.043	1.000	1.000	1.000	1.000	1.000	1.000	
c. Coverages	0.974	0.984	0.952	0.973	0.996	0.815	0.970	
d. Interest	0.995	0.995	0.995	0.995	0.995	0.995	0.995	
Adjusted Base Cost	$ 28.05	$ 3.91	$ 58.88	$ 2.30	$ 0.27	$ 2.96	$ 0.78	$ 97.15
5. Legislative Adjs.	1.084	1.047	1.009	1.031	1.188	1.104	1.044	
6. Trend Adjustments								
a. Cost per Unit	1.000	1.100	1.050	1.000	1.000	0.950	1.000	
b. Units per Eligible	0,950	1.000	1.050	0.950	1.050	1.050	1.000	
Projected Cost per Eligible	$ 28.89	$ 4.50	$ 65.50	$ 2.25	$ 0.34	$ 3.26	$ 0.81	$ 105.55
7. Stop Loss Reins.	Amount		$ 0	Rate		0.0%		0.00
6. CHOP								5.04
9. Fee-for-Service Adj.						-3.0%		(3.32)
Capitation Rate								$ 107.27

Department of Health Services, Rate Development Branch

Plan Name: Molina Medical Center	Plan#: 356	Date: 16-Nov-99
Country: San Bernardino	Plan Type: Commercial Plan	Base Period: FY 96/97
Aid Code Grouping: Adult		

Adjusted Rate is Effective August 1,1999 to September 30,1999

Capitation Payments at the Beginning of the Month

Coverages

Coverage	Status
CCS Indicated Claims	NOT Covered by the Plan
Mental Health Outpatient Services	NOT Covered by the Plan
Mental Health Pharmacy Costs	NOT Covered by the Plan
Mental Health Hospital inpatient Services	NOT Covered by the Plan
Eyewear	NOT Covered by the Plan
Heroin Detoxification	NOT Covered by the Plan
AIDS Waiver Services	NOT Covered by the Plan
Adult Day Health Care	NOT Covered by the Plan
Chiropractor/Acupuncture	NOT Covered by the Plan
Local Education Authority	NOT Covered by the Plan
Alphafeto Protein Testing	NOT Covered by the Plan
Long Term Care for month of entry plus one	Covered by the Plan
Long Term Care after month of entry plus one	NOT Covered by the Plan
Special AIDS drugs	NOT Covered by the Plan

C6 to Contract :No. 95-23637
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Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	FFSE	FQHC Total
1. Average Cost Per Unit	$ 90.48	$ 17.11	$ 1,140.81	$ 15.76	$ 812.04	$ 36.13	$ 68.10	
2. Units per Eligible	21.541	5.818	5.446	4.679	0.000	10.172	0.577	
3. Addt'l Capitation Amts	$ 0.37	$ 0.06	$ 35.62	$ 0.08	$ 0.00	$ 0.00	$ 0.00	
Cost per Elig. per Mo.	$ 162.79	$ 8.36	$ 553.36	$ 6.23	$ 0.00	$ 30.63	$ 3.28	$ 764.65
4. Adjustments								
a. Demographics	1.000	1.000	1.000	1.000	1.000	1.000	1.000	
b. Area	1.043	1.000	1.000	1.000	1.000	1.000	1.000	
c. Coverages	0.999	0.999	0.999	0.989	1.000	0.809	0.995	
d. Interest	0.995	0.995	0.995	0.995	0.995	0.995	0.995	
Adjusted Base Cost	$ 168.77	$ 8.31	$ 550.04	$ 6.13	$ 0.00	$ 24.66	$ 3.25	$ 761.16
5. Legislative Adjs.	1.038	1.054	1.007	1.031	1.154	1.018	1.029	
6. Trend Adjustments								
a. Cost per Unit	1.000	1.100	1.050	1.000	1.000	0.950	1.000	
b. Units per Eligible	0.950	1.000	1.050	0.950	1.050	1.050	1.000	
Projected Cost per Eligible	$ 166.42	$ 9.63	$ 610.66	$ 6.00	$ 0.00	$ 25.04	$ 3.34	$ 821.09
7. Stop Loss Reins.	Amount		$ 0	Rate		0.0%		0.00
6. CHOP								0.00
9. Fee-for-Service Adj.						-3.0%		(24.63)
Capitation Rate								$ 796.46

Plan Name: Molina Medical Center | Plan#: 356 | Date: 16-Nov-99
Country: San Bernardino | Plan Type: Commercial Plan | Base Period: FY 96/97
Aid Code Grouping: AIDS

Adjusted Rate is Effective August 1,1999 to September 30, 1999

Capitation Payments at the Beginning of the Month

Coverages

Coverage	Status
CCS Indicated Claims	NOT Covered by the Plan
Menial Health Outpatient Services	NOT Covered by the Plan
Mental Health Pharmacy Costs	NOT Covered by the Plan
Mental Health Hospital Inpatient Services	NOT Covered by the Plan
Eyewear	NOT Covered by the Plan
Heroin Detoxification	NOT Covered by the Plan
AIDS Waiver Services	NOT Covered by the Plan
Adult Day Health Care	NOT Covered by the Plan
Chiropractor/Acupuncture	NOT Covered by the Plan
Local Education Authority	NOT Covered by the Plan
Alphafeto Protein Testing	NOT Covered by the Plan
Long Term Care for month of entry plus one	Covered by the Plan
Long Term Care after month of entry plus one	NOT Covered by the Plan
Special AIDS drugs	NOT Covered by the Plan

C6 to Contract No. 95-23637

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	FQHC FFSE	Total
1. Average Cost Per Unit	$ 32.67	$ 126.04	$ 611.26	$ 13.79	$ 139.87	$ 42.30	$ 69.96	
2. Units per Eligible	26.584	74.792	3.169	9.882	0.000	36.392	0.349	
3. Addt'l Capitation Amts	$ 2.96	$ 0.09	$ 9.89	$ 0.02	$ 0.00	$ 0.00	$ 0.00	
Cost per Elig. per Mo.	$ 75.33	$ 785.66	$ 171.31	$ 11.38	$ 0.00	$ 128.28	$ 2.04	$ 1,174.00
4. Adjustments								
a. Demographics	1.000	1.000	1.000	1.000	1.000	1.000	1,000	
b. Area	1.043	1.000	1.000	1.000	1.000	1.000	1.000	
c. Coverages	0.918	0.648	0.957	0.992	0.998	0.599	0.951	
d. Interest	0.995	0.995	0.995	0.995	0.995	0.995	0.995	
Adjusted Base Cost	$ 71.77	$ 506.56	$ 163.12	$ 11.23	$ 0.00	$ 76.46	$ 1.93	$ 831.07
5. Legislative Adjs.	0.969	1.006	0.980	0.984	1.242	0.983	0.988	
6. Trend Adjustments								
a. Cost per Unit	1.000	1.100	1.050	1.000	1.100	1.100	1.000	
b. Units per Eligible	1.100	1.210	1.050	1.045	0.950	1.000	1.000	
Projected Cost per Eligible	$ 76.50	$ 678.28	$ 176.24	$ 11.55	$ 0.00	$ 82.68	$ 1.91	$ 1,027.16
7. Stop Loss Reins.	Amount		$ 0	Rate		0.0%		0.00
6. CHOP								0.00
9. Fee-for-Service Adj.						-3.0%		(30.81)
Capitation Rate								$ 996.35

Aid Group: Poverty-47/72 Base: Statewide
Rate Period: August 1999 to September Base Period: FY 96/97

Services ==>	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Nursing Facility	Other	FQHC	Totals
1. Base Cost	$ 10.66	$ 7.27	$ 20.52	$ 5.31	$ 0.14	$ 2.92	$ 5.42	$52.24
2. Age/Sex Adjustments	1.000	1.000	1.000	1.000	1.000	1.000	1.000	
3. Eligibility Adjustments	1.000	1.000	1.000	1.OOO	1.000	1.000	1.000	
4. Coverage Adjustments	0.997	0.997	0.999	0.964	1.000	0.891	0.991	
5. Interest Offset	0.990	0.996	0.987	0.989	0.993	0.990	0.994	
Contract Cost FY 96/97	$ 10.52	$ 7.22	$ 20.24	$ 5.07	$ 0.14	$ 2.57	$ 5.34	$51.10
6. Legislative Adjustments	1.054	0.740	0.997	1.031	1.111	1.167	1.038	
7. Trend Adjustments								
a. Cost Per Unit	1.000	1.308	1.055	0.970	1.000	1.445	1.071	
b. Utilization	1.000	1.027	1.050	1.000	1.107	1.000	1.265	
Projected Cost 10/98-9/99	$ 11.09	$ 7.18	$ 22.35	$ 5.07	$ 0.17	$ 4.33	$ 7.51	$57.70
8. CHDP								$ 2.54
9. Administrative Allowance					1.6%			$ 0.96
Fee-for-Service Equivalent Cost								$61.20
Adjustment to Fee-for Service					94%			$(3.67)
Capitation Rate (payments at beginning of month)								$57.53

01/21/2000-Department of Health Services, Rate Development Branch

Aid Group: Poverty - 7 A Base: Statewide Family Age Adjusted
Rate Period : August 1999 to September Base Period: FY 96/97'

Services==>	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Nursing Facility	Other	FQHC	Totals
1. Base Cost	$ 10.40	$ 6.74	$ 13.64	$ 3.91	$ 0.24	$ 8.30	$ 2.98	$46.21
2. Age/Sex Adjustments	1.000	1.000	1.000	1.000	1,000	1.000	1.000	
3. Eligibility Adjustments	1,000	1.000	1.000	1.000	1.000	1.000	1.000	
4. Coverage Adjustments	0.997	0.997	0.999	0.964	1.000	0.891	0.991	
5. Interest Offset	0.990	0.996	0.987	0.989	0.993	0.990	0.994	
Contract Cost FY 96/97	$ 10.27	$ 6.69	$ 13.45	$ 3.73	$ 0.24	$ 7.32	$ 2.93	$44.63
6. Legislative Adjustments	1.054	0.740	0.997	1.031	1.111	1.167	1.038	
7. Trend Adjustments								
a. Cost Per Unit	1.000	1.308	1.055	0.970	1.000	1.445	1.071	
b. Utilization	1.000	1.027	1.050	1.000	1.107	1.000	1.265	
Projected Cost 10/98-9/99	$ 10.82	$ 6.65	$ 14.85	$ 3.73	$ 0.30	$ 12.34	$ 4.12	$52.81
8. CHDP								$ 2.54
9. Administrative Allowance					1.6%			$ 0.89
Fee-for-Service Equivalent Cost								$56.24
Adjustment to Fee-for Service					94%			$(3.37)
Capitation Rate (payments at beginning of month)								$52.87

Plan Name: Molina Medical Center   Plan #: 355   Date: 16-Nov-99
County: Riverside   Plan Type: Commercial Plan Base Period: Fy 96/97
Aid Code Grouping Family

Adjusted Rate is Effective August 1, 1999 to September 30, 1999

Capitation Payments at the Beginning of the Month

Coverages

CCS Indicated Claims	NOT Covered by the Plan
Mental Health Outpatient Services	NOT Covered by the Plan
Mental Health Pharmacy Costs	NOT Covered by the Plan
Mental Health Hospital Inpatient Services	NOT Covered by the Plan
Eyewear	NOT Covered by the Plan
Heroin Detoxification	NOT Covered by the Plan
AiDS Waiver Services	NOT Covered by the Plan
Adult Day Health Care	NOT Covered by the Plan
Chiropractor/Acupuncture	NOT Covered by the Plan
Local Education Authority	NOT Covered by the Plan
Alphafeto Protein Testing	NOT Covered by the Plan
Long Term Care for month of entry plus one	Covered by the Plan
Long Term Care after month of entry plus one	NOT Covered by the Plan
Special AIDS drugs	NOT Covered by the Plan

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	FQHC FFSE	Total
1. Average Cost Per Unit	$ 69.46	$ 19.86	$ 864.71	$ 16.16	$ 812.04	$ 20.09	$ 68.39	
2. Units per Eligible	4.014	4.683	0.373	2.146	0.004	3.532	0.168	
3. Addt'l Capitation Amts	$ 0.37	$ 0.05	$ 4.62	$ 0.00	$ 0.00	$ 0.00	$ 0.00	
Cost per Elig. per Mo.	$ 23.60	$ 7.81	$ 31.50	$ 2.90	$ 0.27	$ 5.91	$ 0.96	$ 72.95
4. Adjustments								
a. Demographics	1.004	0.976	1.023	1.002	1.000	0.985	0.994	
b. Area	1.043	1.000	1.000	1.000	1.000	1.000	1.000	
c. Coverages	0.975	0.992	0.968	0.956	0.995	0.833	0.935	
d. Interest	0.995	0.995	0.995	0.995	0.995	0.995	0.995	
Adjusted Base Cost	$ 23.97	$ 7.52	$ 31.04	$ 2.76	$ 0.27	$ 4.82	$ 0.89	$ 71.27
5. Legislative Adjs.	1.061	1.053	1.006	1.031	1.195	1.061	1.041	
6. Trend Adjustments								
a. Cost per Unit	1.000	1.100	1.050	1.000	1.000	0.950	1.000	
b. Units per Eligible	0.950	1.210	1.050	0.950	0.050	1.050	1.000	
Projected Cost per Eligible	$ 24.16	$ 8.71	$ 34.43	$ 2.70	$ 0.34	$ 5.10	$ 0.93	$ 76.37
7. Stop Loss Reins.	Amount		$ 0	Rate		0.0%		0.00
6. CHOP								0.00
9. Fee-for-Service Adj.						-3.0%		(2.44)
Capitation Rate								$ 78.99

Department of Health Services, Rate Development Branch

Plan Name: Molina Medical Center   Plan #: 355   Date: 16-Nov-99
County: Riverside   Plan Type: Commercial Plan   Base Period: Fy 96/97
Aid Code Grouping: Aged

Adjusted Rate is Effective August 1,1999 to September 30,1999   Capitation Payments at the Beginning of the Month

Coverages

CCS Indicated Claims	NOT Covered by the Plan
Menial Health Outpatient Services	NOT Covered by the Plan
Menial Health Pharmacy Costs	NOT Covered by the Plan
Mental Health Hospital Inpatient Services	NOT Covered by the Plan
Eyewear	NOT Covered by the Plan
Heroin Detoxification	NOT Covered by the Plan
AIDS Waiver Services	NOT Covered by the Plan
Adult Day Health Care	NOT Covered by the Plan
Chiropractor/Acupuncture	NOT Covered by the Plan
Local Education Authority	NOT Covered by the Plan
Alphafeto Protein Testing	NOT Covered by the Plan
Long Term Care for month of entry plus one	Covered by the Plan
Long Term Care after month of entry plus one	NOT Covered by the Plan
Special AIDS drugs	NOT Covered by the Plan

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	FQHC FFSE	Total
1. Average Cost Per Unit	$ 48.90	$ 32.71	$ 287.24	$ 10.02	$ 77.33	$ 6.41	$ 28.59	
2. Units per Eligible	4.472	21.914	1.265	3.306	2.016	12.862	0.132	
3. Addt'l Capitation Amts	$ 1.29	$ 0.00	$ 7.41	$ 0.02	$ 0.00	$ 0.00	$ 0.00	
Cost per Elig. per Mo.	$ 19.51	$ 59.73	$ 37.69	$ 2.78	$ 12.99	$ 6.87	$ 0.31	$ 139.88
4. Adjustments								
a. Demographics	0.955	1.019	0.957	0.970	1.039	1.025	0.970	
b. Area	1.043	1.000	1.000	1.000	1.000	1.000	1.000	
c. Coverages	0.981	0.996	0.997	0.986	0.997	0.791	0.603	
d. Interest	0.995	0.995	0.995	0.995	0.995	0.995	0.995	
Adjusted Base Cost	$ 18.97	$ 60.32	$ 35.78	$ 2.65	$ 13.39	$ 5.54	$ 0.18	$ 136.83
5. Legislative Adjs.	0.947	1.049	0.933	0.939	1.194	0.941	0.939	
6. Trend Adjustments								
a. Cost per Unit	1.100	1.100	1.100	1.050	1.000	1.050	1.000	
b. Units per Eligible	1.100	1.155	1.100	1.100	0.050	0.950	1.000	
Projected Cost per Eligible	$ 21.74	$ 80.39	$ 40.39	$ 2.87	$ 15.99	$ 5.20	$ 0.17	$ 166.75
7. Stop Loss Reins.	Amount		$ 0	Rate		0.0%		0.00
6. CHOP								0.00
9. Fee-for-Service Adj.						-3.0%		(5.00)
Capitation Rate								$ 161.75

Department of Health Services, Rate Development Branch

Plan Name: Molina Medical Center Plan #: 355 Date: 16-Nov-99
County: Riverside Plan Type: Commercial Plan Base Period: Fy 96/97
Aid Code Grouping: Disabled

Adjusted Rate is Effective August 1, 1999 to September 30, 1999 Capitation Payments at the Beginning of the Month

Coverages

Coverage	Status
CCS Indicated Claims	NOT Covered by the Plan
Mental health Outpatient Services	NOT Covered by the Plan
Mental Health Pharmacy Costs	NOT Covered by the Plan
Mental Health Hospital Inpatient Services	NOT Covered by the Plan
Eyewear	NOT Covered by the Plan
Heroin Detoxification	NOT Covered by the Plan
AIDS Waiver Services	NOT Covered by the Plan
Adult Day Health Care	NOT Covered by the Plan
Chiropractor/Acupuncture	NOT Covered by the Plan
Local Education Authority	NOT Covered by the Plan
Alphafeto Protein Testing	NOT Covered by the Plan
Long Term Care for month of entry plus one	Covered by the Plan
Long Term Care after month of entry plus one	NOT Covered by the Plan
Special AIDS drugs	NOT Covered by the Plan

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	FQHC FFSE	Total
1. Average Cost Per Unit	$ 46.41	$ 39.70	$ 485.15	$ 12.37	$ 139.87	$ 10.16	$ 66.52	
2. Units per Eligible	6.873	26.861	1.556	5.050	0.459	21.959	0.216	
3. Addt'l Capitation Amts	$ 2.96	$ 0.09	$ 9.89	$ 0.02	$ 0.00	$ 0.00	$ 0.00	
Cost per Elig. per Mo.	$ 29.54	$ 88.96	$ 72.80	$ 5.23	$ 5.35	$ 18.59	$ 1.20	$ 221.67
4. Adjustments								
a. Demographics	0.983	0.989	0.981	0.998	1.000	1.015	0.987	
b. Area	1.043	1.000	1.000	1.000	1.000	1.000	1.000	
c. Coverages	0.900	0.875	0.920	0.973	0.995	0.878	0.863	
d. Interest	0.995	0.995	0.995	0.995	0.995	0.995	0.995	
Adjusted Base Cost	$ 27.12	$ 76.60	$ 65.37	$ 5.05	$ 5.30	$ 16.48	$ 1.02	$ 196.94
5. Legislative Adjs.	0.949	1.043	0.927	0.939	1.184	0.937	0.945	
6. Trend Adjustments								
a. Cost per Unit	1.000	1.100	1.050	1.000	1.100	1.100	1.000	
b. Units per Eligible	1.100	1.210	1.050	1.045	0.950	1.000	1.000	
Projected Cost per Eligible	$ 28.31	$ 106.34	$ 66.81	$ 4.96	$ 6.56	$ 16.99	$ 0.96	$ 230.93
7. Stop Loss Reins.		Amount	$ 0	Rate		0.0%		0.00
6. CHOP								0.00
9. Fee-for-Service Adj						-3.0%		(6.93)
Capitation Rate								$ 224.00

Plan Name:	Molina Medical Center	Plan#: 355	Date: 16-Nov-99
Country:	San Bernardino	Plan Type: Commercial Plan	Base Period: FY 96/97
Aid Code Grouping:	Child		

Adjusted Rate is Effective August 1,1999 to September 30, 1999

Capitation Payments at the Beginning of the Month

Coverages

CCS Indicated Claims	NOT Covered by the Plan
Menial Health Outpatient Services	NOT Covered by the Plan
Mental Health Pharmacy Costs	NOT Covered by the Plan
Mental Health Hospital Inpatient Services	NOT Covered by the Plan
Eyewear	NOT Covered by the Plan
Heroin Detoxification	NOT Covered by the Plan
AIDS Waiver Services	NOT Covered by the Plan
Adult Day Health Care	NOT Covered by the Plan
Chiropractor/Acupuncture	NOT Covered by [ha Plan
Local Education Authority	NOT Covered by the Plan
Alphafeto Protein Testing	NOT Covered by the Plan
Long Term Care for month of entry plus one	Covered by the Plan
Long Term Care after month of entry plus one	NOT Covered by the Plan
Special AIDS drugs	NOT Covered by the Plan

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	FQHC FFSE	Total
1. Average Cost Per Unit	$ 67.42	$ 13.64	$ 889.41	$ 16.21	$ 469.38	$ 20.69	$ 68.39	
2. Units per Eligible	3.999	3.411	0.465	1.516	0.007	1.958	0.168	
3. Addt'l Capitation Amts	$ 0.23	$ 0.03	$ 2.90	$ 0.00	$ 0.00	$ 0.00	$ 0.00	
Cost per Elig. per Mo.	$ 22.70	$ 3.91	$ 37.36	$ 2.05	$ 0.27	$ 3.38	$ 0.96	$ 70.63
4. Adjustments								
a. Demographics	1.181	1.019	1.321	1.114	1.000	1.165	1.003	
b. Area	1.043	1.000	1.000	1.000	1.000	1.000	1.000	
c. Coverages	0.974	0.984	0.952	0.973	0.996	0.815	0.970	
d. Interest	0.995	0.995	0.995	0.995	0.995	0.995	0.995	
Adjusted Base Cost	$ 27.10	$ 3.90	$ 46.75	$ 2.21	$ 0.27	$ 3.19	$ 0.93	$ 84.35
5. Legislative Adjs.	1.084	1.047	1.009	1.031	1.188	1.104	1.044	
6. Trend Adjustments								
a. Cost per Unit	1.000	1.100	1.050	1.000	1.000	0.950	1.000	
b. Units per Eligible	0.950	1.000	1.050	0.950	1.050	1.050	1.000	
Projected Cost per Eligible	$ 27.91	$ 4.49	$ 52.01	$ 2.16	$ 0.34	$ 3.51	$ 0.97	$ 91.39
7. Stop Loss Reins.	Amount		$ 0	Rate		0.0%		0.00
6. CHOP								5.04
9. Fee-for-Service Adj.						-3.0%		(2.89)
Capitation Rate								$ 93.54

Department of Health Services, Rate Development Branch

Plan Name: Molina Medical Center — Plan#: 355 — Date: 16-Nov-99
Country: San Bernardino — Plan Type: Commercial Plan — Base Period: FY 96/97
Aid Code Grouping: Adult

Adjusted Rate is Effective August 1,1999 to September 30, 1999

Capitation Payments at the Beginning of the Month

Coverages

CCS Indicated Claims	NOT Covered by the Plan
Menial Health Outpatient Services	NOT Covered by the Plan
Mental Health Pharmacy Costs	NOT Covered by the Plan
Mental Health Hospital Inpatient Services	NOT Covered by the Plan
Eyewear	NOT Covered by the Plan
Heroin Detoxification	NOT Covered by the Plan
AIDS Waiver Services	NOT Covered by the Plan
Adult Day Health Care	NOT Covered by the Plan
Chiropractor/Acupuncture	NOT Covered by [ha Plan
Local Education Authority	NOT Covered by the Plan
Alphafeto Protein Testing	NOT Covered by the Plan
Long Term Care for month of entry plus one	Covered by the Plan
Long Term Care after month of entry plus one	NOT Covered by the Plan
Special AIDS drugs	NOT Covered by the Plan

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	FQHC FFSE	Total
1. Average Cost Per Unit	$ 90.48	$ 17.11	$ 964.66	$ 15.76	$ 812.04	$ 36.13	$ 68.39	
2. Units per Eligible	21.383	5.818	5.446	4.679	0.000	10.172	0.735	
3. Addt'l Capitation Amts	$ 0.37	$ 0.06	$ 35.62	$ 0.08	$ 0.00	$ 0.00	$ 0.00	
Cost per Elig. per Mo.	$ 161.60	$ 8.36	$ 473.41	$ 6.23	$ 0.00	$ 30.63	$ 4.19	$ 684.42
4. Adjustments								
a. Demographics	1.000	1.000	1.000	1.000	1.000	1.000	1.000	
b. Area	1.043	1.000	1.000	1.000	1.000	1.000	1.000	
c. Coverages	0.999	0.999	0.999	0.989	1.000	0.809	0.995	
d. Interest	0.995	0.995	0.995	0.995	0.995	0.995	0.995	
Adjusted Base Cost	$ 167.54	$ 8.31	$ 470.57	$ 6.13	$ 0.00	$ 24.66	$ 4.15	$ 681.36
5. Legislative Adjs.	1.038	1.054	1.007	1.031	1.154	1.018	1.029	
6. Trend Adjustments								
a. Cost per Unit	1.000	1.100	1.050	1.000	1.000	0.950	1.000	
b. Units per Eligible	0.950	1.000	1.050	0.950	1.050	1.050	1.000	
Project Cost per Eligible	$ 165.21	$ 9.63	$ 522.44	$ 6.00	$ 0.00	$ 25.04	$ 4.27	$ 732.59
7. Stop Loss Reins.	Amount		$0	Rate		0.0%		0.00
8. CHDP								0.00
9. Fee-for-Service Adj.						-3.0%		(21.98)
Capitation Rate								$ 710.61

Department of Health Services, Rate Development Branch

Plan Name: Molina Medical Center Plan #: 355
County: Riverside Plan Type: Commercial Plan
Ald Code Grouping: AIDS

Date: 16-Nov-99
Base Period: FY 96/97

Adjusted Rate is Effective August 1,1999 to September 30,1999
Capitation Payments at the Beginning of the Month

Coverages

Coverage	Status
CCS Indicated Claims	NOT Covered by the Plan
Mental Health Outpatient Services	NOT Covered by the Plan
Mental Health Pharmacy Costs	NOT Covered by the Plan
Mental Health Hospital Inpatient Services	NOT Covered by the Plan
Eyewear	NOT Covered by the Plan
Heroin Detoxification	NOT Covered by the Plan
AIDS Waiver Services	NOT Covered by the Plan
Adult Day Health Care	NOT Covered by the Plan
Chiropractor/Acupuncture	NOT Covered by the Plan
Local Education Authority	NOT Covered by the Plan
Alphafeto Protein Testing	NOT Covered by the Plan
Long Term Care for month of entry plus one	Covered by the Plan
Long Term Care alter month of entry plus one	NOT Covered by the Plan
Special AIDS drugs	NOT Covered by the Plan

C6 to Contract No.95-23637
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Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	FQHC FFSE	Total
1. Average Cost Per Unit	$ 32.67	$ 126.04	$ 485.15	$ 13.79	$ 139.87	$ 42.30	$ 66.52	
2. Units per Eligible	26.305	74.792	3.169	9.882	0.000	36.392	0.628	
3. Addt'l Capitation Amts.	$ 2.96	$ 0.09	$ 9.89	$ 0.02	$ 0.00	$ 0.00	$ 0.00	
Cost per Elig. per Mo.	$ 74.57	$ 785.66	$ 138.01	$ 11.38	$ 0.00	$ 128.28	$ 3.48	$ 1,141.38
4. Adjustments								
a. Demographics	1.000	1.000	1.000	1.000	1.000	1.000	1.000	
b. Area	1.043	1.000	1.000	1.000	1.000	1.000	1.000	
c. Coverages	0.918	0.648	0.957	0.992	0.998	0.599	0.951	
d. Interest	0.995	0.995	0.995	0.995	0.995	0.995	0.995	
Adjusted Base Cost	$ 71.04	$ 506.56	$ 131.42	$ 11.23	$ 0.00	$ 76.46	$ 3.29	$ 800.00
5. Legislative Adjs.	0.969	1.006	0.980	0.984	1.242	0.983	0.988	
6. Trend Adjustments								
a. Cost per Unit	1.000	1.100	1.050	1.000	1.100	1.100	1.000	
b. Units per Eligible	1.100	1.210	1.050	1.045	0.950	1.000	1.000	
Projected Cost per Eligible	$ 75.72	$ 678.28	$ 141.99	$ 11.55	$ 0.00	$ 82.68	$ 3.25	$ 993.47
7. Stop Loss Reins.		Amount	50		Rate	0.0%		0.00
8. CHDP								0.00
9. Fee-for-Service Adj.						-3.0%		(29.80)
Capitation Rate								$ 963.67

Department of Health Services, Rate Development Branch

Aid Group: Poverty-47/72
Rate Period: August 1999 to September   Base: Statewide
Base Period: FY 96/97

Services===>	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Nursing Facility	Other	FQHC	Total
1. Base Cost	$ 10.66	$ 7.27	$ 20.52	$ 5.31	$ 0.14	$ 2.92	$ 5.42	$ 52.24
2. Age/Sex Adjustments	1.000	1.000	1.000	1.000	1.000	1.000	1.000	
3. Eligibility Adjustments	1.000	1.000	1.000	1.000	1.000	1.000	1.000	
4. Coverage Adjustments	0.997	0.997	0.999	0.964	1.000	0.891	0.991	
5. Interest Offset	0.990	0.996	0.987	0.989	0.993	0.990	0.994	
Contract Cost FY 96/97	$ 10.52	$ 7.22	$ 20.24	$ 5.07	$ 0.14	$ 2.57	$ 5.34	$ 51.10
6. Legislative Adjustments	1.054	0.740	0.997	1.031	1.111	1.167	1.038	
7. Trend Adjustments								
a. Cost per Unit	1.000	1.308	1.055	0.970	1.000	1.445	1.071	
b. Utilization	1.000	1.027	1.050	1.000	1.107	1.000	1.265	
Projected Cost 10/98-9/99	$ 11.09	$ 7.18	$ 22.35	$ 5.07	$ 0.17	$ 4.33	$ 7.51	$ 57.70
8. CHDP								$ 2.54
9. Administrative Allowance					1.6%			$ 0.96
Fee-for-Service Equivalent Cost								$ 61.20
Adjustment to Fee-for Service					94%			$ (3.67)
Capitation Rate (payments at beginning of month)								$ 57.53

Aid Group: Poverty-7A Base: Statewide Family Age Adjusted
Rate Period: August 1999 to September Base Period: FY 96/97

Services===>	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Nursing Facility	Other	FQHC	Total
1. Base Cost	$ 10.40	$ 6.74	$ 13.64	$ 3.91	$ 0.24	$ 8.30	$ 2.98	$ 46.21
2. Age/Sex Adjustments	1.000	1.000	1.000	1.000	1.000	1.000	1.000	
3. Eligibility Adjustments	1.000	1.000	1.000	1.000	1.000	1.000	1.000	
4. Coverage Adjustments	0.997	0.997	0.999	0.964	1.000	0.891	0.991	
5. Interest Offset	0.990	0.996	0.987	0.989	0.993	0.990	0.994	
Contract Cost FY 96/97	$ 10.27	$ 6.69	$ 13.45	$3.73	$ 0.24	$ 7.32	$ 2.93	$ 44.63
6. Legislative Adjustments	1.054	0.740	0.997	1.031	1.111	1.167	1.038	
7. Trend Adjustment								
a. Cost per Unit	1.000	1.308	1.055	0.970	1.000	1.445	1.071	
b. Utilization	1.000	1.027	1.050	1.000	1.107	1.000	1.265	
Projected Cost 10/98-9/99	$ 10.82	$ 6.65	$ 14.85	$ 3.73	$ 0.30	$ 12.34	$ 4.12	$ 52.81
8. CHDP							$ 2.54	
9. Administrative Allowance					1.6%		$ 0.89	
Fee-for-Service Equivalent Cost							$ 56.24	
Adjustment to Fee-for Service					94%		$ (3.37)	
Capitation Rate (payment at beginning of month)							$ 52.87	

Plan Name: Molina Medical Center
County: San Bernardino Plan #: Commercial Plan
Aid Code Grouping: Family Plan Type: 356

Date: 01-Dec-99
Base Period: FY 96/97

The Rate Period is October 1, 1999 to September 30,2000 Capitation Payments at the End of the Month

Coverage Adjustments

CCS Indicated Claims	NOT Covered by the Plan
Mental Health Outpatient Services	NOT Covered by the Plan
Mental Health Pharmacy Costs	NOT Covered by the Plan
Mental Health Hospital Inpatient Services	NOT Covered by the Plan
Eyewear	NOT Covered by the Plan
Heroin Detoxification	NOT Covered by the Plan
AIDS Waiver Services	NOT Covered by the Plan
Adult Day Health Care	NOT Covered by the Plan
Chiropractor/Acupuncture	NOT Covered by the Plan
Local Education Authority	NOT Covered by the Plan
Alphafeto Protein Testing	NOT Covered by the Plan
Long Term Care for month of entry plus one	Covered by the Plan
Long Term Care after month of entry plus one	NOT Covered by the Plan
Special AIDS drugs	NOT Covered by the Plan

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	Total
1. Average Cost Per Unit	$ 66.25	$ 23.82	$ 978.02	$ 20.37	$ 229.41	$ 8.79	
2. Units per Eligible	5.957	3.361	0.304	2.609	0.009	6.410	
Cost per Elig. per Mo.	$ 32.89	$ 6.67	$ 24.78	$ 4.43	$ 0.17	$ 4.70	$ 73.64
Adjustments							
a. Demographics	0.829	0.863	0.714	0.835	1.000	0.871	
b. Area	1.008	1.000	1.000	1.000	1.000	1.000	
c. Coverages	0.975	0.992	0.968	0.956	0.995	0.868	
d. Interest	1.000	1.000	1.000	1.000	1.000	1.000	
Adjusted Base Cost	$ 26.80	$ 5.71	$ 17.13	$ 3.54	$ 0.17	$ 3.55	$ 56.90
3. Legislative Adjs.	1.139	0.975	1.012	1.034	1.159	1.065	
4. Trend Adjustments							
a. Cost per Unit	1.000	1.100	1.000	1.000	1.100	1.000	
b. Units per Eligible	1.000	0.998	1.045	1.000	1.000	1.100	
Projected Cost per Eligible	$ 30.53	$ 6.11	$ 18.12	$ 3.66	$ 0.20	$ 4.16	$ 62.78
5. Stop Loss Reins.	Amount		$ 0	Rate		0.0%	0.00
6. CHDP							4.88
7. Fee-for-Service Adj.						26.1%	16.41
Capitation Rate							$ 84.07

Plan Name: Molina Medical Center
County: San Bernardino Plan #: Commercial Plan
Aid Code Grouping: Aged Plan Type : 356

Date: 01-Dec-99
Base Period: FY 96/97

The Rate Period is October 1, 1999 to September 30,2000
Capitation Payments at the End of the Month

Coverage Adjustments

CCS Indicated Claims	NOT Covered by the Plan
Mental Health Outpatient Services	NOT Covered by the Plan
Mental Health Pharmacy Costs	NOT Covered by the Plan
Mental Health Hospital Inpatient Services	NOT Covered by the Plan
Eyewear	NOT Covered by the Plan
Heroin Detoxification	NOT Covered by the Plan
AIDS Waiver Services	NOT Covered by the Plan
Adult Day Health Care	NOT Covered by the Plan
Chiropractor/Acupuncture	NOT Covered by the Plan
Local Education Authority	NOT Covered by the Plan
Alphafeto Protein Testing	NOT Covered by the Plan
Long Term Care for month of entry plus one	Covered by the Plan
Long Term Care after month of entry plus one	NOT Covered by the Plan
Special AIDS drugs	NOT Covered by the Plan

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	Total
1. Average Cost Per Unit	$ 16.06	$ 38.28	$ 316.16	$ 11.67	$ 177.26	$ 6.49	
2. Units per Eligible	11.563	16.963	0.819	3.904	1.049	42.784	
Cost per Elig. per Mo.	$ 15.48	$ 54.11	$ 21.58	$ 3.80	$ 15.50	$ 23.14	$ 133.61
Adjustments							
a. Demographics	0.964	1.019	0.964	0.983	1.034	1.022	
b. Area	1.008	1.000	1.000	1.000	1.000	1.000	
c. Coverages	0.981	0.996	0.997	0.986	0.997	0.781	
d. Interest	1.000	1.000	1.000	1.000	1.000	1.000	
Adjusted Base Cost	$ 14.76	$ 54.92	$ 20.74	$ 3.68	$ 15.98	$ 18.47	$ 128.55
3. Legislative Adjs.	0.952	0.920	0.940	1.035	1.159	0.932	
4. Trend Adjustments							
a. Cost per Unit	1.000	1.100	1.100	1.000	1.000	1.000	
b. Units per Eligible	1.050	0.998	0.950	1.045	0.950	1.100	
Projected Cost per Eligible	$ 14.75	$ 55.47	$ 20.37	$ 3.98	$ 17.59	$ 18.94	$ 131.10
5. Stop Loss Reins.	Amount		$ 0		Rate	0.0%	0.00
6. CHDP							0.00
7. Fee-for-Service Adj.						11.0%	14.42
Capitation Rate							$ 145.52

Plan Name: Molina Medical Center
County: San Bernardino Plan #: Commercial Plan
Aid Code Grouping: Disabled Plan Type: 356

Date: 01-Dec-99
Base Period: FY 96/97

The Rate Period is October 1, 1999 to September 30,2000
Capitation Payments at the End of the Month

Coverage Adjustments

CCS Indicated Claims	NOT Covered by the Plan
Mental Health Outpatient Services	NOT Covered by the Plan
Mental Health Pharmacy Costs	NOT Covered by the Plan
Mental Health Hospital Inpatient Services	NOT Covered by the Plan
Eyewear	NOT Covered by the Plan
Heroin Detoxification	NOT Covered by the Plan
AIDS Waiver Services	NOT Covered by the Plan
Adult Day Health Care	NOT Covered by the Plan
Chiropractor/Acupuncture	NOT Covered by the Plan
Local Education Authority	NOT Covered by the Plan
Alphafeto Protein Testing	NOT Covered by the Plan
Long Term Care for month of entry plus one	Covered by the Plan
Long Term Care after month of entry plus one	NOT Covered by the Plan
Special AIDS drugs	NOT Covered by the Plan

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	Total
1. Average Cost Per Unit	$ 20.15	$ 50.42	$ 611.26	$ 18.26	$ 184.85	$ 7.07	
2. Units per Eligible	13.720	21.892	1.011	6.029	0.452	63.930	
Cost per Elig. per Mo.	$ 23.04	$ 91.98	$ 51.50	$ 9.17	$ 6.96	$ 37.67	$ 220.32
Adjustments							
a. Demographics	0.942	0.851	0.850	1.019	0.995	1.023	
b. Area	1.008	1.000	1.000	1.000	1.000	1.000	
c. Coverages	0.900	0.875	0.920	0.973	0.995	0.877	
d. Interest	1.000	1.000	1.000	1.000	1.000	1.000	
Adjusted Base Cost	$ 19.69	$ 68.49	$ 40.27	$ 9.09	$ 6.89	$ 33.80	$ 178.23
3. Legislative Adjs.	0.969	0.920	0.933	1.035	1.159	0.956	
4. Trend Adjustments							
a. Cost per Unit	1.000	1.100	1.100	1.000	1.000	1.000	
b. Units per Eligible	1.050	0.998	0.903	0.950	1.000	1.100	
Projected Cost per Eligible	$ 20.03	$ 69.17	$ 37.32	$ 8.94	$ 7.99	$ 35.54	$ 178.99
5. Stop Loss Reins.		Amount	$ 0		Rate	0.0%	0.00
6. CHDP							0.00
7. Fee-for-Service Adj.						11.0%	19.69
Capitation Rate							$ 198.68

Plan Name: Molina Medical Center
County: San Bernardino   Plan #: Commercial Plan
Aid Code Grouping: Child   Plan Type: 356

Date: 01-Dec-99
Base Period: FY 96/97

The Rate Period is October 1,1999 to September 30,2000
Capitation Payments at the End of the Month

Coverages Adjustments

CCS Indicated Claims	NOT Covered by the Plan
Mental Health Outpatient Services	NOT Covered by the Plan
Mental Health Pharmacy Costs	NOT Covered by the Plan
Mental Health Hospital Inpatient Services	NOT Covered by the Plan
Eyewear	NOT Covered by the Plan
Heroin Detoxification	NOT Covered by the Plan
AIDS Waiver Services	NOT Covered by the Plan
Adult Day Health Care	NOT Covered by the Plan
Chiropractor/Acupuncture	NOT Covered by the Plan
Local Education Authority	NOT Covered by the Plan
Alphafeto Protein Testing	NOT Covered by the Plan
Long Term Care for month of entry plus one	Covered by the Plan
Long Term Care after month of entry plus one	NOT Covered by the Plan
Special AIDS drugs	NOT Covered by the Plan

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	Total
1. Average Cost Per Unit	$ 58.40	$ 17.50	$ 1,120.53	$ 18.79	$ 140.26	$ 6.45	
2. Units per Eligible	5.196	3.068	0.436	2.787	0.019	10.564	
Cost per Elig. per Mo.	$ 25.29	$ 4.47	$ 40.71	$ 4.36	$ 0.22	$ 5.68	$ 80.73
Adjustments							
a. Demographics	0.927	0.989	0.778	0.935	1.000	0.946	
b. Area	1.008	1.000	1.000	1.000	1.000	1.000	
c. Coverages	0.974	0.984	0.952	0.973	0.996	0.882	
d. Interest	1.000	1.000	1.000	1.000	1.000	1.000	
Adjusted Base Cost	$ 23.02	$ 4.35	$ 30.15	$ 3.97	$ 0.22	$ 4.74	$ 66.45
3. Legislative Adjs.	1.155	1.055	1.019	1.034	1.159	1.069	
4. Trend Adjustments							
a. Cost per Unit	1.000	1.100	1.000	1.000	1.000	1.000	
b. Units per Eligible	1.000	0.998	1.045	1.000	1.000	1.100	
Projected Cost per Eligible	$ 26.59	$ 5.04	$ 32.11	$ 4.10	$ 0.25	$ 5.57	$ 73.66
5. Stop Loss Reins.	Amount		$ 0	Rate		0.0%	0.00
6. CHDP							4.06
7. Fee-for-Service Adj.						11.0%	8.10
Capitation Rate							$ 85.82

Plan Name: Molina Medical Center
County: San Bernardino   Plan #: Commercial Plan
Aid Code Grouping: Adult   Plan Type : 356

Date: 01-Dec-99
Base Period: FY 96/97

The Rate Period is October 1, 1999 to September 30,2000
Capitation Payments at the End of the Month

Coverage Adjustments

CCS Indicated Claims	NOT Covered by the Plan
Mental Health Outpatient Services	NOT Covered by the Plan
Mental Health Pharmacy Costs	NOT Covered by the Plan
Mental Health Hospital Inpatient Services	NOT Covered by the Plan
Eyewear	NOT Covered by the Plan
Heroin Detoxification	NOT Covered by the Plan
AIDS Waiver Services	NOT Covered by the Plan
Adult Day Health Care	NOT Covered by the Plan
Chiropractor/Acupuncture	NOT Covered by the Plan
Local Education Authority	NOT Covered by the Plan
Alphafeto Protein Testing	NOT Covered by the Plan
Long Term Care for month of entry plus one	Covered by the Plan
Long Term Care after month of entry plus one	NOT Covered by the Plan
Special AIDS drugs	NOT Covered by the Plan

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	Total
1. Average Cost Per Unit	$ 164.23	$ 19.84	$ 1,140.81	$ 19.73	$ 0.00	$ 30.86	
2. Units per Eligible	22.157	4.314	4.387	17.657	0.000	8.468	
Cost per Elig. per Mo.	$ 303.24	$ 7.13	$ 417.06	$ 29.03	$ 0.00	$ 21.78	$ 778.24
Adjustments							
a. Demographics	1.000	1.000	1.000	1.000	1.000	1.000	
b. Area	1.008	1.000	1.000	1.000	1.000	1.000	
c. Coverages	0.999	0.999	0.999	0.989	1.000	0.887	
d. Interest	1.000	1.000	1.000	1.000	1.000	1.000	
Adjusted Base Cost	$ 305.43	$ 7.12	$ 416.64	$ 28.71	$ 0.00	$ 19.32	$ 777.22
3. Legislative Adjs.	1.059	0.945	1.011	1.034	1.159	1.071	
4. Trend Adjustments							
a. Cost per Unit	1.000	1.100	1.000	1.000	1.000	1.000	
b. Units per Eligible	1.000	0.998	1.045	1.000	1.000	1.100	
Projected Cost per Eligible	$ 323.45	$ 7.39	$ 440.18	$ 29.69	$ 0.00	$ 22.76	$ 823.47
5. Stop Loss Reins.	Amount		$ 0	Rate		0.0%	0.00
6. CHDP							0.00
7. Fee-for-Service Adj.						11.0%	90.58
Capitation Rate							$ 914.05

Plan Name: Molina Medical Center
County: San Bernardino   Plan #: Commercial Plan
Aid Code Grouping: AIDS   Plan Type: 356

Date: 01-Dec-99
Base Period: FY 96/97

The Rate Period is October 1,1999 to September 30,2000
Capitation Payments at the End of the Month

Coverage Adjustments

CCS Indicated Claims	NOT Covered by the Plan
Mental Health Outpatient Services	NOT Covered by the Plan
Mental Health Pharmacy Costs	NOT Covered by the Plan
Mental Health Hospital Inpatient Services	NOT Covered by the Plan
Eyewear	NOT Covered by the Plan
Heroin Detoxification	NOT Covered by the Plan
AIDS Waiver Services	NOT Covered by the Plan
Adult Day Health Care	NOT Covered by the Plan
Chiropractor/Acupuncture	NOT Covered by the Plan
Local Education Authority	NOT Covered by the Plan
Alphafeto Protein Testing	NOT Covered by the Plan
Long Term Care for month of entry plus one	Covered by the Plan
Long Term Care after month of entry plus one	NOT Covered by the Plan
Special AIDS drugs	NOT Covered by the Plan

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	Total
1. Average Cost Per Unit	$ 25.87	$ 141.75	$ 611.26	$ 17.75	$ 228.06	$ 14.00	
2. Units per Eligible	29.254	46.897	3.823	28.506	0.450	78.563	
Cost per Elig. per Mo.	$ 63.07	$ 553.97	$ 194.74	$ 42.17	$ 8.55	$ 91.66	$ 954.16
Adjustments							
a. Demographics	1.000	1.000	1.000	1.000	1.000	1.000	
b. Area	1.008	1.000	1.000	1.000	1.000	1.000	
c. Coverages	0.918	0.648	0.957	0.992	0.998	0.642	
d. Interest	1.000	1.000	1.000	1.000	1.000	1.000	
Adjusted Base Cost	$ 58.37	$ 358.97	$ 186.37	$ 41.83	$ 8.53	$ 58.85	$ 712.92
3. Legislative Adjs.	0.982	0.843	0.981	1.009	1.159	0.989	
4. Trend Adjustments							
a. Cost per Unit	1.000	1.100	1.100	1.000	1.000	1.000	
b. Units per Eligible	1.050	0.998	0.903	0.950	1.000	1.100	
Projected Cost per Eligible	$ 60.19	$ 332.21	$ 181.60	$ 40.10	$ 9.89	$ 64.02	$ 688.01
5. Stop Loss Reins.	Amount		$ 0	Rate		0.0%	0.00
6. CHDP							0.00
7. Fee-for-Service Adj.						11.0%	75.68
Capitation Rate							$ 763.69

Plan Name: Molina Medical Center
County: Riverside   Plan #: Commercial Plan
Aid Code Grouping: Family   Plan Type: 355

Date: 01-Dec-99
Base Period: FY 96/97

The Rate Period is October 1,1999 to September 30,2000
Capitation Payments at the End of the Month

Coverage Adjustments

CCS Indicated Claims	NOT Covered by the Plan
Mental Health Outpatient Services	NOT Covered by the Plan
Mental Health Pharmacy Costs	NOT Covered by the Plan
Mental Health Hospital Inpatient Services	NOT Covered by the Plan
Eyewear	NOT Covered by the Plan
Heroin Detoxification	NOT Covered by the Plan
AIDS Waiver Services	NOT Covered by the Plan
Adult Day Health Care	NOT Covered by the Plan
Chiropractor/Acupuncture	NOT Covered by the Plan
Local Education Authority	NOT Covered by the Plan
Alphafeto Protein Testing	NOT Covered by the Plan
Long Term Care for month of entry plus one	Covered by the Plan
Long Term Care after month of entry plus one	NOT Covered by the Plan
Special AIDS drugs	NOT Covered by the Plan

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	Total
1. Average Cost Per Unit	$ 66.25	$ 23.82	$ 864.71	$ 20.37	$ 229.41	$ 8.79	
2. Units per Eligible	5.957	3.361	0.304	2.609	0.009	6.410	
Cost per Elig. per Mo.	$ 32.89	$ 6.67	$ 21.91	$ 4.43	$ 0.17	$ 4.70	$ 70.77
Adjustments							
a. Demographics	0.883	0.8750	0.853	0.903	1.000	0.866	
b. Area	1.008	1.000	1.000	1.000	1.000	1.000	
c. Coverages	0.975	0.992	0.968	0.956	0.995	0.868	
d. Interest	1.000	1.000	1.000	1.000	1.000	1.000	
Adjusted Base Cost	$ 28.55	$ 5.79	$ 18.09	$ 3.82	$ 0.17	$ 3.53	$ 59.95
3. Legislative Adjs.	1.139	0.975	1.012	1.034	1.159	1.065	
4. Trend Adjustments							
a. Cost per Unit	1.000	1.100	1.000	1.000	1.000	1.000	
b. Units per Eligible	1.000	0.998	1.045	1.000	1.000	1.100	
Projected Cost per Eligible	$ 32.52	$ 6.20	$ 19.13	$ 3.95	$ 0.20	$ 4.14	$ 66.14
5. Stop Loss Reins.	Amount		$ 0	Rate		0.0%	0.00
6. CHDP							4.88
7. Fee-for-Service Adj.						13.0%	8.59
Capitation Rate							$ 79.61

Plan Name: Molina Medical Center
County: Riverside   Plan #: Commercial Plan
Aid Code Grouping: Aged   Plan Type: 355

Date: 01-Dec-99
Base Period: FY 96/97

The Rate Period is October 1,1999 to September 30,2000
Capitation Payments at the End of the Month

Coverage Adjustments

Service	Coverage
CCS Indicated Claims	NOT Covered by the Plan
Mental Health Outpatient Services	NOT Covered by the Plan
Mental Health Pharmacy Costs	NOT Covered by the Plan
Mental Health Hospital Inpatient Services	NOT Covered by the Plan
Eyewear	NOT Covered by the Plan
Heroin Detoxification	NOT Covered by the Plan
AIDS Waiver Services	NOT Covered by the Plan
Adult Day Health Care	NOT Covered by the Plan
Chiropractor/Acupuncture	NOT Covered by the Plan
Local Education Authority	NOT Covered by the Plan
Alphafeto Protein Testing	NOT Covered by the Plan
Long Term Care for month of entry plus one	Covered by the Plan
Long Term Care after month of entry plus one	NOT Covered by the Plan
Special AIDS drugs	NOT Covered by the Plan

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	Total
1. Average Cost Per Unit	$ 16.06	$ 38.28	$ 287.24	$ 11.67	$ 177.26	$ 6.49	
2. Units per Eligible	11.563	16.963	0.819	3.904	1.049	42.784	
Cost per Elig. per Mo.	$ 15.48	$ 54.11	$ 19.60	$ 3.80	$ 15.50	$ 23.14	$ 131.63
Adjustments							
a. Demographics	0.953	1.025	0.958	0.968	1.035	1.021	
b. Area	1.008	1.000	1.000	1.000	1.000	1.000	
c. Coverages	0.981	0.996	0.997	0.986	0.997	0.781	
d. Interest	1.000	1.000	1.000	1.000	1.000	1.000	
Adjusted Base Cost	$ 14.59	$ 55.24	$ 18.72	$ 3.63	$ 15.99	$ 18.45	$ 126.62
3. Legislative Adjs.	0.952	0.920	0.940	1.035	1.159	0.932	
4. Trend Adjustments							
a. Cost per Unit	1.000	1.100	1.100	1.000	1.000	1.000	
b. Units per Eligible	1.050	0.998	0.950	1.045	0.950	1.100	
Projected Cost per Eligible	$ 14.58	$ 55.79	$ 18.39	$ 3.93	$ 17.61	$ 18.91	$ 129.21
5. Stop Loss Reins.	Amount		$ 0	Rate		0.0%	0.00
6. CHDP							0.00
7. Fee-for-Service Adj.						11.0%	14.21
Capitation Rate							$ 143.42

Plan Name: Molina Medical Center
County: Riverside Plan #: Commercial Plan
Aid Code Grouping: Disabled Plan Type: 355

Date: 01-Dec-99
Base Period: FY 96/97

The Rate Period is October 1,1999 to September 30,2000 \
Capitation Payments at the End of the Month

Coverage Adjustments

CCS Indicated Claims	NOT Covered by the Plan
Mental Health Outpatient Services	NOT Covered by the Plan
Mental Health Pharmacy Costs	NOT Covered by the Plan
Mental Health Hospital Inpatient Services	NOT Covered by the Plan
Eyewear	NOT Covered by the Plan
Heroin Detoxification	NOT Covered by the Plan
AIDS Waiver Services	NOT Covered by the Plan
Adult Day Health Care	NOT Covered by the Plan
Chiropractor/Acupuncture	NOT Covered by the Plan
Local Education Authority	NOT Covered by the Plan
Alphafeto Protein Testing	NOT Covered by the Plan
Long Term Care for month of entry plus one	Covered by the Plan
Long Term Care after month of entry plus one	NOT Covered by the Plan
Special AIDS drugs	NOT Covered by the Plan

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	Total
1. Average Cost Per Unit	$ 20.15	$ 50.42	$ 485.15	$ 18.26	$ 184.85	$ 7.07	
2. Units per Eligible	13.720	21.892	1.011	6.029	0.452	63.930	
Cost per Elig. per Mo.	$ 23.04	$ 91.98	$ 40.87	$ 9.17	$ 6.96	$ 37.67	$ 209.69
Adjustments							
a. Demographics	1.027	0.895	0.946	1.076	0.937	1.053	
b. Area	1.008	1.000	1.000	1.000	1.000	1.000	
c. Coverages	0.900	0.875	0.920	0.973	0.995	0.877	
d. Interest	1.000	1.000	1.000	1.000	1.000	1.000	
Adjusted Base Cost	$ 21.47	$ 72.03	$ 35.57	$ 9.60	$ 6.49	$ 34.79	$ 179.95
3. Legislative Adjs.	0.969	0.920	0.933	1.035	1.159	0.956	
4. Trend Adjustments							
a. Cost per Unit	1.000	1.100	1.100	1.000	1.000	1.000	
b. Units per Eligible	1.050	0.998	0.903	0.950	1.000	1.100	
Projected Cost per Eligible	$ 21.84	$ 72.75	$ 32.96	$ 9.44	$ 7.52	$ 36.59	$ 181.10
5. Stop Loss Reins.	Amount		$ 0	Rate		0.0%	0.00
6. CHDP							0.00
7. Fee-for-Service Adj.						11.0%	19.92
Capitation Rate							$ 201.02

Plan Name: Molina Medical Center
County: Riverside Plan #: Commercial Plan
Aid Code Grouping: Child Plan Type: 355

Date: 01-Dec-99
Base Period: FY 96/97

The Rate Period is October 1,1999 to September 30,2000
Capitation Payments at the End of the Month

Coverage Adjustments

Service	Coverage
CCS Indicated Claims	NOT Covered by the Plan
Mental Health Outpatient Services	NOT Covered by the Plan
Mental Health Pharmacy Costs	NOT Covered by the Plan
Mental Health Hospital Inpatient Services	NOT Covered by the Plan
Eyewear	NOT Covered by the Plan
Heroin Detoxification	NOT Covered by the Plan
AIDS Waiver Services	NOT Covered by the Plan
Adult Day Health Care	NOT Covered by the Plan
Chiropractor/Acupuncture	NOT Covered by the Plan
Local Education Authority	NOT Covered by the Plan
Alphafeto Protein Testing	NOT Covered by the Plan
Long Term Care for month of entry plus one	Covered by the Plan
Long Term Care after month of entry plus one	NOT Covered by the Plan
Special AIDS drugs	NOT Covered by the Plan

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	Total
1. Average Cost Per Unit	$ 58.40	$ 17.50	$ 889.41	$ 18.79	$ 140.26	$ 6.45	
2. Units per Eligible	5.196	3.068	0.436	2.787	0.019	10.564	
Cost per Elig. per Mo.	$ 25.29	$ 4.47	$ 32.32	$ 4.36	$ 0.22	$ 5.68	$ 72.34
Adjustments							
a. Demographics	1.156	1.020	1.155	1.139	1.000	1.048	
b. Area	1.008	1.000	1.000	1.000	1.000	1.000	
c. Coverages	0.974	0.984	0.952	0.973	0.996	0.882	
d. Interest	1.000	1.000	1.000	1.000	1.000	1.000	
Adjusted Base Cost	$ 28.71	$ 4.49	$ 35.54	$ 4.83	$ 0.22	$ 5.25	$ 79.04
3. Legislative Adjs.	1.155	1.055	1.019	1.034	1.159	1.069	
4. Trend Adjustments							
a. Cost per Unit	1.000	1.100	1.000	1.000	1.000	1.000	
b. Units per Eligible	1.000	0.998	1.045	1.000	1.000	1.100	
Projected Cost per Eligible	$ 33.16	$ 5.20	$ 37.84	$ 4.99	$ 0.25	$ 6.17	$ 87.61
5. Stop Loss Reins.	Amount		$ 0	Rate		0.0%	0.00
6. CHDP							4.06
7. Fee-for-Service Adj.						11%	9.64
Capitation Rate							$ 101.31

Plan Name: Molina Medical Center
County: Riverside Plan #: Commercial Plan
Aid Code Grouping: Adult Plan Type: 355

Date: 01-Dec-99
Base Period: FY 96/97

The Rate Period is October 1,1999 to September 30,2000
Capitation Payments at the End of the Month

Coverage Adjustments

CCS Indicated Claims	NOT Covered by the Plan
Mental Health Outpatient Services	NOT Covered by the Plan
Mental Health Pharmacy Costs	NOT Covered by the Plan
Mental Health Hospital Inpatient Services	NOT Covered by the Plan
Eyewear	NOT Covered by the Plan
Heroin Detoxification	NOT Covered by the Plan
AIDS Waiver Services	NOT Covered by the Plan
Adult Day Health Care	NOT Covered by the Plan
Chiropractor/Acupuncture	NOT Covered by the Plan
Local Education Authority	NOT Covered by the Plan
Alphafeto Protein Testing	NOT Covered by the Plan
Long Term Care for month of entry plus one	Covered by the Plan
Long Term Care after month of entry plus one	NOT Covered by the Plan
Special AIDS drugs	NOT Covered by the Plan

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	Total
1. Average Cost Per Unit	$ 164.23	$ 19.84	$ 964.66	$ 19.73	$ 0.00	$ 30.86	
2. Units per Eligible	22.157	4.314	4.387	17.657	0.000	8.468	
Cost per Elig. per Mo.	$ 303.24	$ 7.13	$ 352.66	$ 29.03	$ 0.00	$ 21.78	$ 713.84
Adjustments							
a. Demographics	1.000	1.000	1.000	1.000	1.000	1.000	
b. Area	1.008	1.000	1.000	1.000	1.000	1.000	
c. Coverages	0.999	0.999	0.999	0.989	1.000	0.887	
d. Interest	1.000	1.000	1.000	1.000	1.000	1.000	
Adjusted Base Cost	$ 305.43	$ 7.12	$ 352.31	$ 28.71	$ 0.00	$ 19.32	$ 712.89
3. Legislative Adjs.	1.059	0.945	1.011	1.034	1.159	1.071	
4. Trend Adjustments							
a. Cost per Unit	1.000	1.100	1.000	1.000	1.000	1.000	
b. Units per Eligible	1.000	0.998	1.045	1.000	1.000	1.100	
Projected Cost per Eligible	$ 323.45	$ 7.39	$ 372.21	$ 29.69	$ 0.00	$ 22.76	$ 755.50
5. Stop Loss Reins.	Amount		$ 0	Rate		0.0%	0.00
6. CHDP							0.00
7. Fee-for-Service Adj.						11.0%	83.10
Capitation Rate							$ 838.60

Plan Name: Molina Medical Center
County: Riverside Plan #: Commercial Plan
Aid Code Grouping: AIDS Plan Type: 355

Date: 01-Dec-99
Base Period: FY 96/97

The Rate Period is October 1,1999 to September 30,2000
Capitation Payments at the End of the Month

Coverage Adjustments

CCS Indicated Claims	NOT Covered by the Plan
Mental Health Outpatient Services	NOT Covered by the Plan
Mental Health Pharmacy Costs	NOT Covered by the Plan
Mental Health Hospital Inpatient Services	NOT Covered by the Plan
Eyewear	NOT Covered by the Plan
Heroin Detoxification	NOT Covered by the Plan
AIDS Waiver Services	NOT Covered by the Plan
Adult Day Health Care	NOT Covered by the Plan
Chiropractor/Acupuncture	NOT Covered by the Plan
Local Education Authority	NOT Covered by the Plan
Alphafeto Protein Testing	NOT Covered by the Plan
Long Term Care for month of entry plus one	Covered by the Plan
Long Term Care after month of entry plus one	NOT Covered by the Plan
Special AIDS drugs	NOT Covered by the Plan

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	Total
1. Average Cost Per Unit	$ 25.87	$ 141.75	$ 485.15	$ 17.75	$ 228.06	$ 14.00	
2. Units per Eligible	29.254	46.897	3.823	28.506	0.450	78.563	
Cost per Elig. per Mo.	$ 63.07	$ 553.97	$ 154.56	$ 42.17	$ 8.55	$ 91.66	$ 913.98
Adjustments							
a. Demographics	1.000	1.000	1.000	1.000	1.000	1.000	
b. Area	1.008	1.000	1.000	1.000	1.000	1.000	
c. Coverages	0.918	0.648	0.957	0.992	0.998	0.642	
d. Interest	1.000	1.000	1.000	1.000	1.000	1.000	
Adjusted Base Cost	$ 58.37	$ 358.97	$ 147.91	$ 41.83	$ 8.53	$ 58.85	$ 674.46
3. Legislative Adjs.	0.982	0.843	0.981	1.009	1.159	0.989	
4. Trend Adjustments							
a. Cost per Unit	1.000	1.100	1.100	1.000	1.000	1.000	
b. Units per Eligible	1.050	0.998	0.903	0.950	1.000	1.100	
Projected Cost per Eligible	$ 60.19	$ 332.21	$ 144.13	$ 40.10	$ 9.89	$ 64.02	$ 650.54
5. Stop Loss Reins.	Amount		$ 0	Rate		0.0%	0.00
6. CHDP							0.00
7. Fee-for-Service Adj.						11.0%	71.56
Capitation Rate							$ 722.10

[LETTER HEAD OF DEPARTMENT OF HEALTH SERVICES]

DEPARTMENT OF HEALTH SERVICES
714/744 P Street
P.O. Box 942732
Sacramento, CA 94234-7320
(916)654-8076

[SEAL]

March 1, 2000

George Goldstein
Molina
One Golden Shore
Long Beach, CA 90802

Dear Mr. Goldstein:

Change Order Number C7 to Contract No.95-23637 is being provided to rectify the capitation payment schedule from prepaid to postpaid in accordance with Article V, Section 5.3, Capitation Rates and Section 5.4 Capitation Rates Constitute Payment in Full, of your Contract for the periods February 1, 1998 through September 30, 1998; October 1, 1998 through June 30, 1999 (Includes FQHC); July 1, 1999 through July 31, 1999 (excludes FQHC); and August 1, 1999 through September 30, 1999. Corresponding postpaid rate sheets are attached. This Change Order is effective March 1, 2000.

The retropayment for the above mentioned periods will be processed and payment should be mailed within three (3) to six (6) weeks from the date of this letter.

If you have any questions, please contact your contract manager.

Sincerely,

/s/
Susanne M. Hughes
Acting Chief
Medi-Cal Managed Care Division

Enclosures

[LETTER HEAD OF DEPARTMENT OF HEALTH SERVICES]

1. 5.3 CAPITATION RATES

DHS will remit to the Contractor a capitation payment each month for each Medi-Cal Member that appears on the approved list of Members supplied to the Contractor by DHS. The capitation rate shall be the amount specified in this Article. The payment period for health care services will commence on the first day of operations, as determined by DHS. Capitation payments will be made in accordance with the following schedule of capitation payment rates:

FOR THE PERIOD 2/1/98 - 9/30/98 RIVERSIDE COUNTY

GROUPS	AID CODES	RATE
Family	01, OA, 02, 08, 30, 32, 33, 34, 35, 38, 39, 40, 42, 54, 59, 3A, 3C, 3E, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 7X,	$ 76.14
Disabled	20, 24, 26, 28, 36, 60, 64, 66, 68, 6A, 6C, 6N, 6P, 6R	$ 205.99
Aged	10, 14, 16, 18	$ 163.11
Child	03, 04, 4C, 4K, 5K, 45, 82	$ 79.71
Adult	86	$ 518.25
AIDS Beneficiary		$ 1,026.62

FOR THE PERIOD 2/1/98 - 9/30/98 SAN BERNARDINO COUNTY

GROUPS	AID CODES	RATE
Family	01, 0A, 02, 08, 30, 32, 33, 34, 35, 38, 39, 40, 42, 54, 59, 3A, 3C, 3E, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 7X,	$ 74.39
Disabled	20, 24, 26, 28, 36, 6O, 64, 66, 68, 6A, 6C, 6N, 6P, 6R	$ 218.97
Aged	10, 14, 16, 18	$ 168.09
Child	03, 04, 4C, 4K, 5K, 45, 82	$ 79.79
Adult	86	$ 534.10
AIDS Beneficiary		$ 1,078.17

FOR THE PERIOD 10/1/98 - 6/30/99 RIVERSIDE COUNTY

GROUPS	AID CODES	RATE
Family	01, OA, 02, 08, 30, 32, 33, 34, 35, 38, 39, 40, 42, 54, 59, 3A, 3C, 3E, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 7X,	$ 79.13
Disabled	20, 24, 26, 28, 36, 60, 64, 66, 68, 6A, 6C, 6N, 6P, 6R	$ 223.73
Aged	10, 14, 16, 18	$ 161.27
Child	03, 04, 4C, 4K, 5K, 45,82	$ 93.51
Adult	86	$ 710.32
AIDS Beneficiary		$ 967.27
Percent of Poverty	7A,	$ 54.11
Percent of Poverty	47, 72,	$ 60.05

FOR THE PERIOD 10/1/98 - 6/30/99 SAN BERNARDINO COUNTY

GROUPS	AID CODES	RATE
Family	01, OA, 02, 08, 30, 32, 33, 34, 35, 38, 39, 40, 42, 54, 59, 3A, 3C, 3E, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 7X,	$ 80.89
Disabled	20, 24, 26, 28, 36, 60, 64, 66, 68, 6A, 6C, 6N, 6P, 6R	$ 234.65
Aged	10, 14, 16, 18	$ 164.60
Child	03, 04, 4C, 4K, 5K, 45, 82	$ 106.97
Adult	86	$ 794.86
AIDS Beneficiary		$ 1,000.01
Percent of Poverty	7A,	$ 54.11
Percent of Poverty	47, 72,	$ 60.05

FOR THE PERIOD 7/1/99 - 7/31/99 RIVERSIDE COUNTY

GROUPS	AID CODES	RATE
Family	01, 0A, 02, 08, 30, 32, 33, 34, 35, 38, 39, 40, 42, 54, 59, 3A, 3C, 3E, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 7X,	$ 78.80
Disabled	20, 24, 26, 28, 36, 6O, 64, 66, 68, 6A, 6C, 6N, 6P, 6R	$ 223.73
Aged	10, 14, 16, 18	$ 161.27
Child	03, 04, 4C, 4K, 5K, 45, 82	$ 93.17
Adult	86	$ 708.81
AIDS Beneficiary		$ 967.27
Percent of Poverty	7A,	$ 52.55
Percent of Poverty	47, 72,	$ 57.21

FOR THE PERIOD 7/1/99 - 7/31/99 SAN BERNARDINO COUNTY

GROUPS	AID CODES	RATE
Family	01, 0A, 02, 08, 30, 32, 33, 34, 35, 38, 39, 40, 42, 54, 59, 3A, 3C, 3E, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 7X,	$ 80.82
Disabled	20, 24, 26, 28, 36, 6O, 64, 66, 68, 6A, 6C, 6N, 6P, 6R	$ 234.65
Aged	10, 14, 16, 18	$ 164.60
Child	03, 04, 4C, 4K, 5K, 45, 82	$ 106.89
Adult	86	$ 794.50
AIDS Beneficiary		$ 1,000.01
Percent of Poverty	7A,	$ 52.55
Percent of Poverty	47, 72,	$ 57.21

FOR THE PERIOD 8/1/99 - 9/30/99 RIVERSIDE COUNTY

GROUPS	AID CODES	RATE
Family	01, 0A, 02, 08, 30, 32, 33, 34, 35, 38, 39, 40, 42, 54, 59, 3A, 3C, 3E, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 5X, 7X,	$ 79.37
Disabled	20, 24, 26, 28, 36, 6O, 64, 66, 68, 6A, 6C, 6N, 6P, 6R	$ 225.12
Aged	10, 14, 16, 18	$ 162.55
Child	03, 04, 4C, 4K, 5K, 45, 82	$ 93.95
Adult	86	$ 714.18
AIDS Beneficiary		$ 968.53
Percent of Poverty	7A,	$ 53.10
Percent of Poverty	47, 72,	$ 57.78

GROUPS	AID CODES	RATE
Family	01, 0A, 02, 08, 30, 32, 33, 34, 35, 38, 39, 40, 42, 54, 59, 3A, 3C, 3E, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 5X, 7X,	$ 81.39
Disabled	20, 24, 26, 28, 36, 60, 64, 66, 68, 6A, 6C, 6N, 6P, 6R	$ 236.15
Aged	10,14,16,18	$ 165.90
Child	03, 04, 4C, 4K, 5K, 45, 82	$ 107.81
Adult	86	$ 800.46
AIDS Beneficiary		$ 1,001.35
Percent of Poverty	7A,	$ 53.10
Percent of Poverty	47,72,	$ 57.78

All other terms, conditions, and provisions contained in Section 5.3 remain unchanged.

2. 5.4 CAPITATION RATES CONSTITUTE PAYMENT IN FULL

Capitation rates for each rate period, as calculated by DHS, are prospective rates and constitute payment in full, subject to any stop loss reinsurance provisions, on behalf of a Member for all Covered Services required by such Member and for all Administrative Costs incurred by the Contractor in providing or arranging for such services, and subject to adjustments for federally qualified health centers in accordance with Section 5.13, but do not include payment for the recoupment of current or previous losses incurred by Contractor. DHS is not responsible for making payments for recoupment of losses. The actuarial basis for the determination of the capitation payment rates is outlined in Attachment 1 (consisting of 60 pages).

[LETTER HEAD OF DEPARTMENT OF HEALTH SERVICES]

[SEAL]

[SEAL]

November 20, 2000

Mr. George Goldstein
President
Molina Healthcare of California
Dba Molina
One Golden Shore
Long Beach, CA 90802

Dear Mr. Goldstein:

In accordance with Article V, Section 5.5 of your Contract, the enclosed Change Order No. 08 transmits (Molina's) annual capitation rates for the Period beginning October 1,2000 to September 30, 2001.

The retropayment between the old rates and the new 2000/2001 rates for the period beginning October 1, 2000 will be processed in approximately four to six weeks.

If you have any questions, please contact your contract manager.

Sincerely,

/s/

Susanne M. Hughes
Acting Chief
Medi-Cal Managed Care Division

Enclosure

[LETTER HEAD OF DEPARTMENT OF HEALTH SERVICES]

CHANGE ORDER C08 TO CONTRACT NO.95-23637; ADJUSTING THE ANNUAL CAPITATION RATE FOR PROVIDER RATE INCREASES FOR THE PERIOD OCTOBER 1, 2000 TO SEPTEMBER 30, 2001, BY CHANGING CONTRACT SECTIONS; 5.3 CAPITATION RATES; AND 5.4 CAPITATION RATES CONSTITUTE PAYMENT IN FULL. This Change Order is effective November 1, 2000.

1. 5.3 CAPITATION RATES

For the period October 1, 2000 to September 30,2001 — Riverside County

GROUPS	AID CODES	RATE
Family	01, 0A, 02, 08, 30, 32, 33, 34, 35, 38, 39, 40, 42, 47, 54, 59, 72, 3A, 3C, 3E, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 4F, 4G, 5X, 7X, 8P	$ 86.14
Disabled	20, 24, 26, 28, 36, 60, 64, 66, 68, 6A, 6C, 6N, 6P, 6R	$ 223.64
Aged	10, 14, 16, 18	$ 160.60
Child	03, 04, 4A, 4C, 4K, 5K, 45, 82, 7A, 8R	$ 89.04
Adult	86	$ 843.25
AIDS Beneficiary		$ 847.95

For the period October 1, 2000 to September 30,2001 — San Bernardino County

GROUPS	AID CODES	RATE
Family	01, 0A, 02, 08, 30, 32, 33, 34, 35, 38, 39, 40, 42, 47, 54, 59, 72, 3A, 3C, 3E, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 4F, 4G, 5X, 7X, 8P	$ 82.56
Disabled	20, 24, 26, 28, 36, 60, 64, 66, 68, 6A, 6C, 6N, 6P, 6R	$ 223.41
Aged	10, 14, 16, 18	$ 151.60
Child	03, 04, 4A, 4C, 4K, 5K, 45, 82, 7A, 8R	$ 93.28
Adult	86	$ 922.71
AIDS Beneficiary		$ 891.15

2. 5.4 CAPITATION RATES CONSTITUTE PAYMENT IN FULL

Capitation rates for each rate period, as calculated by DHS, are prospective rates and constitute payment in full, subject to any stop loss reinsurance provisions, on behalf of a Member for all Covered Services required by such Member and for all administrative costs incurred by the Contractor in providing or arranging for such services, and subject to adjustments for federally qualified health centers in accordance with Section 14087.325 of the W&I Code, but do not include payment for recoupment of current or previous losses incurred by Contractor. DHS is not responsible for making payments for recoupment of losses. The actuarial basis for the determination of the capitation payment rates is outlined in Attachment 1 (consisting of 12 pages).

3. All other terms, conditions, and provisions contained in Sections 5.3 and 5.4 remain unchanged.

Plan Name: Molina Medical Center
County: Riverside Plan #: 355
Aid Code Grouping: Family Plan Type: Commercial Plan

Date: 14-Nov-00

The Rate Period is October 1, 2000 to September 30, 2001

Capitation Payments at the End of the Month

Coverages (C = Covered by Plan, N = NOT Covered by Plan)

Coverage		Coverage	
CCS Indicated Claims	N	AIDS Waiver	N
GHPP	C	In Home Waiver	N
Hemodialysis	C	Model NF Waiver	N
Major Organ Transplants	N	Adult Day Health Care	N
Out-of-State	C	Newborn Hearing Screening	N
Chiropractor	N	Psychiatric Drugs	N
Local Education Authority	N	AIDS Drugs	N
Psychiatrist	N	Injections	N
Acupuncturist	N	MH - Hospital Inpatient	N
Alphafeto Protein Testing	N	MH - Outpatient Services	N
Heroin Detoxification	N	Long Term Care for month of entry plus one	C
Direct Observed Therapy	N	Long Term Care after month of entry plus one	N
PIA Lenses	N	CHDP	C

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	Total
1. Average Cost Per Unit	$ 66.25	$ 23.82	$ 864.71	$ 20.37	$ 229.41	$ 8.79	
2. Units per Eligible	5.957	3.361	0.304	2.609	0.009	6.410	
Cost per Elig. per Mo.	$ 32.89	$ 6.67	$ 21.91	$ 4.43	$ 0.17	$ 4.70	$ 70.77
3. Adjustments							
a.Demographics	0.933	0.927	0.903	0.933	1.000	0.938	
b.Area	0.900	1.000	1.000	1.000	1.000	1.000	
c.Coverages	0.975	0.992	0.968	0.956	0.995	0.868	
d.Interest	1.000	1.000	1.000	1.000	1.000	1.000	
Adjusted Base Cost	$ 26.93	$ 6.13	$ 19.15	$ 3.95	$ 0.17	$ 3.83	$ 60.16
4. Legislative Adjs.	1.261	0.895	1.016	1.065	1.375	1.086	
5. Trend Adjustments							
a. Cost per Unit	1.000	1.148	1.000	1.000	1.000	1.000	
b. Units per Eligible	1.000	1.073	1.066	1.000	1.000	1.148	
Projected Cost per Eligible	$ 33.96	$ 6.76	$ 20.73	$ 4.21	$ 0.23	$ 4.77	$ 70.66
6. Adjustment to No Loss							0.00
7. CHDP							4.88
8. Adjustment to Fee-For-Service						15.0%	10.60
Capitation Rate							$ 86.14
Value of Provider Rate Increase							$ 4.44

Prepared by Department of Health Services, Rate Development Branch

Plan Name: Molina Medical Center
County: Riverside — Plan #: 355
Aid Code Grouping: Disabled — Plan Type: Commercial Plan

Date: 14-Nov-00

The Rate Period is October 1, 2000 to September 30, 2001

Capitation Payments at the End of the Month

Coverages (C = Covered by Plan, N = NOT Covered by Plan)

Coverage		Coverage	
CCS Indicated Claims	N	AIDS Waiver	N
GHPP	C	In Home Waiver	N
Hemodialysis	C	Model NF Waiver	N
Major Organ Transplants	N	Adult Day Health Care	N
Out-of-State	C	Newborn Hearing Screening	N
Chiropractor	N	Psychiatric Drugs	N
Local Education Authority	N	AIDS Drugs	N
Psychiatrist	N	Injections	N
Acupuncturist	N	MH - Hospital Inpatient	N
Alphafeto Protein Testing	N	MH - Outpatient Services	N
Heroin Detoxification	N	Long Term Care for month of entry plus one	C
Direct Observed Therapy	N	Long Term Care after month of entry plus one	N
PIA Lenses	N	CHDP	C

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	Total
1. Average Cost Per Unit	$ 20.15	$ 50.42	$ 485.15	$ 18.26	$ 184.85	$ 7.07	
2. Units per Eligible	13.720	21.892	1.011	6.029	0.452	63.930	
Cost per Elig. per Mo.	$ 23.04	$ 91.98	$ 40.87	$ 9.17	$ 6.96	$ 37.67	$ 209.69
3. Adjustments							
a.Demographics	0.990	0.881	0.935	1.064	0.954	1.046	
b.Area	0.900	1.000	1.000	1.000	1.000	1.000	
c.Coverages	0.900	0.875	0.920	0.973	0.995	0.877	
d.Interest	1.000	1.000	1.000	1.000	1.000	1.000	
Adjusted Base Cost	$ 18.48	$ 70.91	$ 35.16	$ 9.49	$ 6.61	$ 34.56	$ 175.21
4. Legislative Adjs.	1.151	0.925	0.952	1.057	1.379	0.991	
5. Trend Adjustments							
a. Cost per Unit	1.000	1.148	1.148	1.000	1.000	1.000	
b. Units per Eligible	1.073	1.073	0.863	0.929	1.000	1.148	
Projected Cost per Eligible	$ 22.82	$ 80.77	$ 33.15	$ 9.31	$ 9.12	$ 39.30	$ 194.47
6. Adjustment to No Loss							0.00
7. CHDP							0.00
8. Adjustment to Fee-For-Service						15.0%	29.17
Capitation Rate							$ 223.64
Value of Provider Rate Increase							$ 4.65

Prepared by Department of Health Services, Rate Development Branch

Plan Name: Molina Medical Center
County: Riverside   Plan #: 355
Aid Code Grouping: Aged   Plan Type: Commercial Plan

Date: 14-Nov-00

The Rate Period is October 1, 2000 to September 30, 2001

Capitation Payments at the End of the Month

Coverages (C = Covered by Plan, N = NOT Covered by Plan)

Coverage		Coverage	
CCS Indicated Claims	N	AIDS Waiver	N
GHPP	C	In Home Waiver	N
Hemodialysis	C	Model NF Waiver	N
Major Organ Transplants	N	Adult Day Health Care	N
Out-of-State	C	Newborn Hearing Screening	N
Chiropractor	N	Psychiatric Drugs	N
Local Education Authority	N	AIDS Drugs	N
Psychiatrist	N	Injections	N
Acupuncturist	N	MH - Hospital Inpatient	N
Alphafeto Protein Testing	N	MH - Outpatient Services	N
Heroin Detoxification	N	Long Term Care for month of entry plus one	C
Direct Observed Therapy	N	Long Term Care after month of entry plus one	N
PIA Lenses	N	CHDP	C

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other		Total
1. Average Cost Per Unit	$ 16.06	$ 38.28	$ 287.24	$ 11.67	$ 177.26	$ 6.49		
2. Units per Eligible	11.563	16.963	0.819	3.904	1.049	42.784		
Cost per Elig. per Mo.	$ 15.48	$ 54.11	$ 19.60	$ 3.80	$ 15.50	$ 23.14		$ 131.63
3. Adjustments								
a.Demographics	1.007	1.014	1.005	1.001	0.975	1.011		
b.Area	0.900	1.000	1.000	1.000	1.000	1.000		
c.Coverages	0.981	0.996	0.997	0.986	0.997	0.781		
d.Interest	1.000	1.000	1.000	1.000	1.000	1.000		
Adjusted Base Cost	$ 13.76	$ 54.65	$ 19.64	$ 3.75	$ 15.07	$ 18.27		$ 125.14
4. Legislative Adjs.	0.993	0.911	0.960	1.052	1.368	0.966		
5. Trend Adjustments								
a. Cost per Unit	1.000	1.148	1.148	1.000	1.000	1.000		
b. Units per Eligible	1.073	1.073	0.929	1.066	0.929	1.148		
Projected Cost per Eligible	$ 14.66	$ 61.31	$ 20.09	$ 4.20	$ 19.14	$ 20.25		$ 139.65
6. Adjustment to No Loss								0.00
7. CHDP								0.00
8. Adjustment to Fee-For-Service							15.0%	20.95
Capitation Rate								$ 160.60
Value of Provider Rate Increase								$ 0.84

Prepared by Department of Health Services, Rate Development Branch

Plan Name: Molina Medical Center
County: Riverside Plan #: 355
Aid Code Grouping: Child Plan Type: Commercial Plan

Date: 14-Nov-00

The Rate Period is October 1, 2000 to September 30, 2001

Capitation Payments at the End of the Month

Coverages (C = Covered by Plan, N = NOT Covered by Plan)

Coverage		Coverage	
CCS Indicated Claims	N	AIDS Waiver	N
GHPP	C	In Home Waiver	N
Hemodialysis	C	Model NF Waiver	N
Major Organ Transplants	N	Adult Day Health Care	N
Out-of-State	C	Newborn Hearing Screening	N
Chiropractor	N	Psychiatric Drugs	N
Local Education Authority	N	AIDS Drugs	N
Psychiatrist	N	Injections	N
Acupuncturist	N	MH - Hospital Inpatient	N
Alphafeto Protein Testing	N	MH - Outpatient Services	N
Heroin Detoxification	N	Long Term Care for month of entry plus one	C
Direct Observed Therapy	N	Long Term Care after month of entry plus one	N
PIA Lenses	N	CHDP	C

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	Total
1. Average Cost Per Unit	$ 58.40	$ 17.50	$ 889.41	$ 18.79	$ 140.26	$ 6.45	
2. Units per Eligible	5.196	3.068	0.436	2.787	0.019	10.564	
Cost per Elig. per Mo.	$ 25.29	$ 4.47	$ 32.32	$ 4.36	$ 0.22	$ 5.68	$ 72.34
3. Adjustments							
a.Demographics	1.020	1.029	0.953	1.033	1.000	0.988	
b.Area	0.900	1.000	1.000	1.000	1.000	1.000	
c.Coverages	0.974	0.984	0.952	0.973	0.996	0.882	
d.Interest	1.000	1.000	1.000	1.000	1.000	1.000	
Adjusted Base Cost	$ 22.61	$ 4.53	$ 29.32	$ 4.38	$ 0.22	$ 4.95	$ 66.01
4. Legislative Adjs.	1.144	0.907	1.019	1.055	1.359	1.089	
5. Trend Adjustments							
a. Cost per Unit	1.000	1.148	1.000	1.000	1.000	1.000	
b. Units per Eligible	1.000	1.073	1.066	1.000	1.000	1.148	
Projected Cost per Eligible	$ 25.87	$ 5.06	$ 31.84	$ 4.62	$ 0.30	$ 6.19	$ 73.88
6. Adjustment to No Loss							0.00
7. CHDP							4.08
8. Adjustment to Fee-For-Service						15.0%	11.08
Capitation Rate							$ 89.04
Value of Provider Rate Increase							$ 0.71

Prepared by Department of Health Services, Rate Development Branch

Plan Name: Molina Medical Center
County: Riverside   Plan #: 355
Aid Code Grouping: Adult   Plan Type: Commercial Plan

Date: 14-Nov-00

The Rate Period is October 1, 2000 to September 30, 2001

Capitation Payments at the End of the Month

Coverages (C = Covered by Plan, N = NOT Covered by Plan)

Coverage		Coverage	
CCS Indicated Claims	N	AIDS Waiver	N
GHPP	C	In Home Waiver	N
Hemodialysis	C	Model NF Waiver	N
Major Organ Transplants	N	Adult Day Health Care	N
Out-of-State	C	Newborn Hearing Screening	N
Chiropractor	N	Psychiatric Drugs	N
Local Education Authority	N	AIDS Drugs	N
Psychiatrist	N	Injections	N
Acupuncturist	N	MH - Hospital Inpatient	N
Alphafeto Protein Testing	N	MH - Outpatient Services	N
Heroin Detoxification	N	Long Term Care for month of entry plus one	C
Direct Observed Therapy	N	Long Term Care after month of entry plus one	N
PIA Lenses	N	CHDP	C

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	Total
1. Average Cost Per Unit	$ 164.23	$ 19.84	$ 964.66	$ 19.73	$ 0.00	$ 30.86	
2. Units per Eligible	22.157	4.314	4.387	17.657	0.000	8.468	
Cost per Elig. per Mo.	$ 303.24	$ 7.13	$ 352.66	$ 29.03	$ 0.00	$ 21.78	$ 713.84
3. Adjustments							
a.Demographics	1.000	1.000	1.000	1.000	1.000	1.000	
b.Area	0.900	1.000	1.000	1.000	1.000	1.000	
c.Coverages	0.999	0.999	0.999	0.989	1.000	0.887	
d.Interest	1.000	1.000	1.000	1.000	1.000	1.000	
Adjusted Base Cost	$ 272.64	$ 7.12	$ 352.31	$ 28.71	$ 0.00	$ 19.32	$ 680.10
4. Legislative Adjs.	1.075	0.900	1.008	1.062	1.213	1.053	
5. Trend Adjustments							
a. Cost per Unit	1.000	1.148	1.000	1.000	1.000	1.000	
b. Units per Eligible	1.000	1.073	1.066	1.000	1.000	1.148	
Projected Cost per Eligible	$ 293.09	$ 7.89	$ 378.44	$ 30.49	$ 0.00	$ 23.35	$ 733.26
6. Adjustment to No Loss							0.00
7. CHDP							0.00
8. Adjustment to Fee-For-Service						15.0%	109.99
Capitation Rate							$ 843.25
Value of Provider Rate Increase							$ 3.39

Prepared by Department of Health Services, Rate Development Branch

Plan Name: Molina Medical Center
County: Riverside   Plan #: 355
Aid Code Grouping: AIDS   Plan Type: Commercial Plan

Date: 14-Nov-00

The Rate Period is October 1, 2000 to September 30, 2001

Capitation Payments at the End of the Month

Coverages (C = Covered by Plan, N = NOT Covered by Plan)

Coverage		Coverage	
CCS Indicated Claims	N	AIDS Waiver	N
GHPP	C	In Home Waiver	N
Hemodialysis	C	Model NF Waiver	N
Major Organ Transplants	N	Adult Day Health Care	N
Out-of-State	C	Newborn Hearing Screening	N
Chiropractor	N	Psychiatric Drugs	N
Local Education Authority	N	AIDS Drugs	N
Psychiatrist	N	Injections	N
Acupuncturist	N	MH - Hospital Inpatient	N
Alphafeto Protein Testing	N	MH - Outpatient Services	N
Heroin Detoxification	N	Long Term Care for month of entry plus one	C
Direct Observed Therapy	N	Long Term Care after month of entry plus one	N
PIA Lenses	N	CHDP	C

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	Total
1. Average Cost Per Unit	$ 25.87	$ 141.75	$ 485.15	$ 17.75	$ 228.06	$ 14.00	
2. Units per Eligible	29.254	46.897	3.823	28.506	0.450	78.563	
Cost per Elig. per Mo.	$ 63.07	$ 553.97	$ 154.56	$ 42.17	$ 8.55	$ 91.66	$ 913.98
3. Adjustments							
a.Demographics	1.000	1.000	1.000	1.000	1.000	1.000	
b.Area	0.900	1.000	1.000	1.000	1.000	1.000	
c.Coverages	0.918	0.663	0.957	0.992	0.998	0.970	
d.Interest	1.000	1.000	1.000	1.000	1.000	1.000	
Adjusted Base Cost	$ 52.11	$ 367.28	$ 147.91	$ 41.83	$ 8.53	$ 88.91	$ 706.57
4. Legislative Adjs.	1.098	0.836	0.986	1.015	1.453	0.996	
5. Trend Adjustments							
a. Cost per Unit	1.000	1.148	1.148	1.000	1.000	1.000	
b. Units per Eligible	1.073	1.073	0.863	0.929	1.000	1.148	
Projected Cost per Eligible	$ 61.39	$ 378.09	$ 144.43	$ 39.43	$ 12.39	$ 101.62	$ 737.35
6. Adjustment to No Loss							0.00
7. CHDP							0.00
8. Adjustment to Fee-For-Service						15.0%	110.60
Capitation Rate							$ 847.95
Value of Provider Rate Increase							$ 7.25

Prepared by Department of Health Services, Rate Development Branch

Plan Name: Molina Medical Center
County: San Bernardino Plan #: 356
Aid Code Grouping: Family Plan Type: Commercial Plan

Date: 14-Nov-00

The Rate Period is October 1, 2000 to September 30, 2001

Capitation Payments at the End of the Month

Coverages (C = Covered by Plan, N = NOT Covered by Plan)

Coverage		Coverage	
CCS Indicated Claims	N	AIDS Waiver	N
GHPP	C	In Home Waiver	N
Hemodialysis	C	Model NF Waiver	N
Major Organ Transplants	N	Adult Day Health Care	N
Out-of-State	C	Newborn Hearing Screening	N
Chiropractor	N	Psychiatric Drugs	N
Local Education Authority	N	AIDS Drugs	N
Psychiatrist	N	Injections	N
Acupuncturist	N	MH - Hospital Inpatient	N
Alphafeto Protein Testing	N	MH - Outpatient Services	N
Heroin Detoxification	N	Long Term Care for month of entry plus one	C
Direct Observed Therapy	N	Long Term Care after month of entry plus one	N
PIA Lenses	N	CHDP	C

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	Total
1. Average Cost Per Unit	$ 66.25	$ 23.82	$ 978.02	$ 20.37	$ 229.41	$ 8.79	
2. Units per Eligible	5.957	3.361	0.304	2.609	0.009	6.410	
Cost per Elig. per Mo.	$ 32.89	$ 6.67	$ 24.78	$ 4.43	$ 0.17	$ 4.70	$ 73.64
3. Adjustments							
a. Demographics	0.870	0.911	0.786	0.871	1.000	0.918	
b. Area	0.900	1.000	1.000	1.000	1.000	1.000	
c. Coverages	0.975	0.992	0.968	0.956	0.995	0.868	
d. Interest	1.000	1.000	1.000	1.000	1.000	1.000	
Adjusted Base Cost	$ 25.11	$ 6.03	$ 18.85	$ 3.69	$ 0.17	$ 3.75	$ 57.60
4. Legislative Adjs.	1.261	0.895	1.016	1.065	1.375	1.086	
5. Trend Adjustments							
a. Cost per Unit	1.000	1.148	1.000	1.000	1.000	1.000	
b. Units per Eligible	1.000	1.073	1.066	1.000	1.000	1.148	
Projected Cost per Eligible	$ 31.66	$ 6.65	$ 20.41	$ 3.93	$ 0.23	$ 4.67	$ 67.55
6. Adjustment to No Loss							0.00
7. CHDP							4.88
8. Adjustment to Fee-For-Service						15.0%	10.13
Capitation Rate							$ 82.56
Value of Provider Rate Increase							$ 4.15

Prepared by Department of Health Services, Rate Development Branch

Plan Name: Molina Medical Center
County: San Bernardino   Plan #: 356
Aid Code Grouping: Disabled   Plan Type: Commercial Plan

Date: 14-Nov-00

The Rate Period is October 1, 2000 to September 30, 2001

Capitation Payments at the End of the Month

Coverages (C = Covered by Plan, N = NOT Covered by Plan)

CCS Indicated Claims	N	AIDS Waiver	N
GHPP	C	In Home Waiver	N
Hemodialysis	C	Model NF Waiver	N
Major Organ Transplants	N	Adult Day Health Care	N
Out-of-State	C	Newborn Hearing Screening	N
Chiropractor	N	Psychiatric Drugs	N
Local Education Authority	N	AIDS Drugs	N
Psychiatrist	N	Injections	N
Acupuncturist	N	MH - Hospital Inpatient	N
Alphafeto Protein Testing	N	MH - Outpatient Services	N
Heroin Detoxification	N	Long Term Care for month of entry plus one	C
Direct Observed Therapy	N	Long Term Care after month of entry plus one	N
PIA Lenses	N	CHDP	C

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other		Total
1. Average Cost Per Unit	$ 20.15	$ 50.42	$ 611.26	$ 18.26	$ 184.85	$ 7.07		
2. Units per Eligible	13.720	21.892	1.011	6.029	0.452	63.930		
Cost per Elig. per Mo.	$ 23.04	$ 91.98	$ 51.50	$ 9.17	$ 6.96	$ 37.67		$ 220.32
3. Adjustments								
a.Demographics	0.927	0.841	0.865	1.023	0.991	1.031		
b.Area	0.900	1.000	1.000	1.000	1.000	1.000		
c.Coverages	0.900	0.875	0.920	0.973	0.995	0.877		
d.Interest	1.000	1.000	1.000	1.000	1.000	1.000		
Adjusted Base Cost	$ 17.30	$ 67.69	$ 40.98	$ 9.13	$ 6.86	$ 34.06		$ 176.02
4. Legislative Adjs.	1.151	0.925	0.952	1.057	1.379	0.991		
5. Trend Adjustments								
a. Cost per Unit	1.000	1.148	1.148	1.000	1.000	1.000		
b. Units per Eligible	1.073	1.073	0.863	0.929	1.000	1.148		
Projected Cost per Eligible	$ 21.37	$ 77.10	$ 38.64	$ 8.96	$ 9.46	$ 38.74		$ 194.27
6. Adjustment to No Loss								0.00
7. CHDP								0.00
8. Adjustment to Fee-For-Service							15.0%	29.14
Capitation Rate								$ 223.41
Value of Provider Rate Increase								$ 4.42

Prepared by Department of Health Services, Rate Development Branch

Plan Name: Molina Medical Center
County: San Bernardino Plan #: 356
Aid Code Grouping: Aged Plan Type: Commercial Plan

Date: 14-Nov-00

The Rate Period is October 1, 2000 to September 30, 2001

Capitation Payments at the End of the Month

Coverages (C = Covered by Plan, N = NOT Covered by Plan)

Coverage		Coverage	
CCS Indicated Claims	N	AIDS Waiver	N
GHPP	C	In Home Waiver	N
Hemodialysis	C	Model NF Waiver	N
Major Organ Transplants	N	Adult Day Health Care	N
Out-of-State	C	Newborn Hearing Screening	N
Chiropractor	N	Psychiatric Drugs	N
Local Education Authority	N	AIDS Drugs	N
Psychiatrist	N	Injections	N
Acupuncturist	N	MH - Hospital Inpatient	N
Alphafeto Protein Testing	N	MH - Outpatient Services	N
Heroin Detoxification	N	Long Term Care for month of entry plus one	C
Direct Observed Therapy	N	Long Term Care after month of entry plus one	N
PIA Lenses	N	CHDP	C

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	Total
1. Average Cost Per Unit	$ 16.06	$ 38.28	$ 316.16	$ 11.67	$ 177.26	$ 6.49	
2. Units per Eligible	11.563	16.963	0.819	3.904	1.049	42.784	
Cost per Elig. per Mo.	$ 15.48	$ 54.11	$ 21.58	$ 3.80	$ 15.50	$ 23.14	$ 133.61
3. Adjustments							
a. Demographics	1.014	1.009	0.894	1.039	0.650	0.962	
b. Area	0.900	1.000	1.000	1.000	1.000	1.000	
c. Coverages	0.981	0.996	0.997	0.986	0.997	0.781	
d. Interest	1.000	1.000	1.000	1.000	1.000	1.000	
Adjusted Base Cost	$ 13.86	$ 54.38	$ 19.23	$ 3.89	$ 10.04	$ 17.39	$ 118.79
4. Legislative Adjs.	0.993	0.911	0.960	1.052	1.368	0.966	
5. Trend Adjustments							
a. Cost per Unit	1.000	1.148	1.148	1.000	1.000	1.000	
b. Units per Eligible	1.073	1.073	0.929	1.066	0.929	1.148	
Projected Cost per Eligible	$ 14.77	$ 61.00	$ 19.67	$ 4.36	$ 12.75	$ 19.28	$ 131.83
6. Adjustment to No Loss							0.00
7. CHDP							0.00
8. Adjustment to Fee-For-Service						15.0%	19.77
Capitation Rate							$ 151.60
Value of Provider Rate Increase							$ 0.81

Prepared by Department of Health Services, Rate Development Branch

Date: 14-Nov-00

Plan Name: Molina Medical Center
County: San Bernardino Plan #: 356
Aid Code Grouping: Child Plan Type: Commercial Plan

The Rate Period is October 1, 2000 to September 30, 2001

Capitation Payments at the End of the Month

Coverages (C = Covered by Plan, N = NOT Covered by Plan)

Coverage		Coverage	
CCS Indicated Claims	N	AIDS Waiver	N
GHPP	C	In Home Waiver	N
Hemodialysis	C	Model NF Waiver	N
Major Organ Transplants	N	Adult Day Health Care	N
Out-of-State	C	Newborn Hearing Screening	N
Chiropractor	N	Psychiatric Drugs	N
Local Education Authority	N	AIDS Drugs	N
Psychiatrist	N	Injections	N
Acupuncturist	N	MH - Hospital Inpatient	N
Alphafeto Protein Testing	N	MH - Outpatient Services	N
Heroin Detoxification	N	Long Term Care for month of entry plus one	C
Direct Observed Therapy	N	Long Term Care after month of entry plus one	N
PIA Lenses	N	CHDP	C

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	Total
1. Average Cost Per Unit	$ 58.40	$ 17.50	$ 1,120.53	$ 18.79	$ 140.26	$ 6.45	
2. Units per Eligible	5.196	3.068	0.436	2.787	0.019	10.564	
Cost per Elig. per Mo.	$ 25.29	$ 4.47	$ 40.71	$ 4.36	$ 0.22	$ 5.68	$ 80.73
3. Adjustments							
a. Demographics	0.986	1.016	0.877	0.987	1.000	0.976	
b. Area	0.900	1.000	1.000	1.000	1.000	1.000	
c. Coverages	0.974	0.984	0.952	0.973	0.996	0.882	
d. Interest	1.000	1.000	1.000	1.000	1.000	1.000	
Adjusted Base Cost	$ 21.86	$ 4.47	$ 33.99	$ 4.19	$ 0.22	$ 4.89	$ 69.62
4. Legislative Adjs.	1.144	0.907	1.019	1.055	1.359	1.089	
5. Trend Adjustments							
a. Cost per Unit	1.000	1.148	1.000	1.000	1.000	1.000	
b. Units per Eligible	1.000	1.073	1.066	1.000	1.000	1.148	
Projected Cost per Eligible	$ 25.01	$ 4.99	$ 36.91	$ 4.42	$ 0.30	$ 6.11	$ 77.74
6. Adjustment to No Loss							0.00
7. CHDP							4.08
8. Adjustment to Fee-For-Service						15.0%	11.66
Capitation Rate							$ 93.48
Value of Provider Rate Increase							$ 0.69

Prepared by Department of Health Services, Rate Development Branch

Date: 14-Nov-00

Plan Name: Molina Medical Center
County: San Bernadino Plan #: 356
Aid Code Grouping: Adult Plan Type: Commercial Plan

The Rate Period is October 1, 2000 to September 30, 2001

Capitation Payments at the End of the Month

Coverages (C = Covered by Plan, N = NOT Covered by Plan)

Coverage		Coverage	
CCS Indicated Claims	N	AIDS Waiver	N
GHPP	C	In Home Waiver	N
Hemodialysis	C	Model NF Waiver	N
Major Organ Transplants	N	Adult Day Health Care	N
Out-of-State	C	Newborn Hearing Screening	N
Chiropractor	N	Psychiatric Drugs	N
Local Education Authority	N	AIDS Drugs	N
Psychiatrist	N	Injections	N
Acupuncturist	N	MH - Hospital Inpatient	N
Alphafeto Protein Testing	N	MH - Outpatient Services	N
Heroin Detoxification	N	Long Term Care for month of entry plus one	C
Direct Observed Therapy	N	Long Term Care after month of entry plus one	N
PIA Lenses	N	CHDP	C

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	Total
1. Average Cost Per Unit	$ 164.23	$ 19.84	$ 1,140.81	$ 19.73	$ 0.00	$ 30.86	
2. Units per Eligible	22.157	4.314	4.387	17.657	0.000	8.468	
Cost per Elig. per Mo.	$ 303.24	$ 7.13	$ 417.06	$ 29.03	$ 0.00	$ 21.78	$ 778.24
3. Adjustments							
a. Demographics	1.000	1.000	1.000	1.000	1.000	1.000	
b. Area	0.900	1.000	1.000	1.000	1.000	1.000	
c. Coverages	0.999	0.999	0.999	0.989	1.000	0.887	
d. Interest	1.000	1.000	1.000	1.000	1.000	1.000	
Adjusted Base Cost	$ 272.64	$ 7.12	$ 416.64	$ 28.71	$ 0.00	$ 19.32	$ 744.43
4. Legislative Adjs.	1.075	0.900	1.008	1.062	1.213	1.053	
5. Trend Adjustments							
a. Cost per Unit	1.000	1.148	1.000	1.000	1.000	1.000	
b. Units per Eligible	1.000	1.073	1.066	1.000	1.000	1.148	
Projected Cost per Eligible	$ 293.09	$ 7.89	$ 447.54	$ 30.49	$ 0.00	$ 23.35	$ 802.36
6. Adjustment to No Loss							0.00
7. CHDP							0.00
8. Adjustment to Fee-For-Service						15.0%	120.35
Capitation Rate							$ 922.71
Value of Provider Rate Increase							$ 3.39

Prepared by Department of Health Services, Rate Development Branch

Plan Name: Molina Medical Center
County: San Bernardino Plan #: 356
Aid Code Grouping: AIDS Plan Type: Commercial Plan

Date: 14-Nov-00

The Rate Period is October 1, 2000 to September 30, 2001

Capitation Payments at the End of the Month

Coverages (C = Covered by Plan, N = NOT Covered by Plan)

Coverage		Coverage	
CCS Indicated Claims	N	AIDS Waiver	N
GHPP	C	In Home Waiver	N
Hemodialysis	C	Model NF Waiver	N
Major Organ Transplants	N	Adult Day Health Care	N
Out-of-State	C	Newborn Hearing Screening	N
Chiropractor	N	Psychiatric Drugs	N
Local Education Authority	N	AIDS Drugs	N
Psychiatrist	N	Injections	N
Acupuncturist	N	MH - Hospital Inpatient	N
Alphafeto Protein Testing	N	MH - Outpatient Services	N
Heroin Detoxification	N	Long Term Care for month of entry plus one	C
Direct Observed Therapy	N	Long Term Care after month of entry plus one	N
PIA Lenses	N	CHDP	C

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	Total
1. Average Cost Per Unit	$ 25.87	$ 141.75	$ 611.26	$ 17.75	$ 228.06	$ 14.00	
2. Units per Eligible	29.254	46.897	3.823	28.506	0.450	78.563	
Cost per Elig. per Mo.	$ 63.07	$ 553.97	$ 194.74	$ 42.17	$ 8.55	$ 91.66	$ 954.16
3. Adjustments							
a. Demographics	1.000	1.000	1.000	1.000	1.000	1.000	
b. Area	0.900	1.000	1.000	1.000	1.000	1.000	
c. Coverages	0.918	0.663	0.957	0.992	0.998	0.970	
d. Interest	1.000	1.000	1.000	1.000	1.000	1.000	
Adjusted Base Cost	$ 52.11	$ 367.28	$ 186.37	$ 41.83	$ 8.53	$ 88.91	$ 745.03
4. Legislative Adjs.	1.098	0.836	0.986	1.015	1.453	0.996	
5. Trend Adjustments							
a. Cost per Unit	1.000	1.148	1.148	1.000	1.000	1.000	
b. Units per Eligible	1.073	1.073	0.863	0.929	1.000	1.148	
Projected Cost per Eligible	$ 61.39	$ 378.09	$ 181.99	$ 39.43	$ 12.39	$ 101.62	$ 774.91
6. Adjustment to No Loss							0.00
7. CHDP							0.00
8. Adjustment to Fee-For-Service						15.0%	116.24
Capitation Rate							$ 891.15
Value of Provider Rate Increase							$ 7.26

Prepared by Department of Health Services, Rate Development Branch

[LETTER HEAD OF DEPARTMENT OF HEALTH SERVICES]

[SEAL]

[SEAL]

January 9, 2001

Mr. George Goldstein
President
Molina Healthcare of California
Dba Molina
One Golden Shore
Long Beach, CA 90802

Dear Mr. Goldstein:

In accordance with Article V, Section 5.5 of your Contract, the enclosed Change Order No. 09 transmits (Molina's) annual capitation rates for the Period August 1, 2000 to September 30, 2000.

The retropayment between the old rates and the new rates for the period August 1, 2000 through September 30, 2000 will be processed in approximately four to six weeks.

If you have any questions, please contact your contract manager.

Sincerely,

/s/

Roberto B. Martinez
Acting Chief
Medi-Cal Managed Care Division

Enclosure

[LETTER HEAD OF DEPARTMENT OF HEALTH SERVICES]

CHANGE ORDER C09 TO CONTRACT NO.95-23637; ADJUSTING THE ANNUAL CAPITATION RATE FOR PROVIDER RATE INCREASES FOR THE PERIOD AUGUST 1, 2000 TO SEPTEMBER 30, 2000, BY CHANGING CONTRACT SECTIONS; 5.3 CAPITATION RATES; AND 5.4 CAPITATION RATES CONSTITUTE PAYMENT IN FULL. This Change Order is effective January 1, 2001.

1. 5.3 CAPITATION RATES

For the period August 1, 2000 to September 30,2000 Riverside County

GROUPS	AID CODES	RATE
Family	01, 0A, 02, 08, 30, 32, 33, 34, 35, 38, 39, 40, 42, 47, 54, 59, 72, 3A, 3C, 3E, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 4F, 4G, 5X, 7X, 8P	$ 84.28
Disabled	20, 24, 26, 28, 36, 60, 64 66, 68, 6A, 6C, 6N, 6P, 6R	$ 205.86
Aged	10, 14, 16, 18	$ 144.20
Child	03, 04, 4A, 4C, 4K, 5K, 45, 82, 7A, 8R	$ 102.15
Adult	86	$ 841.84
AIDS Beneficiary		$ 729.33

For the period August 1, 2000 to September 30,2001 San Bernardino County

GROUPS	AID CODES	RATE
Family	01, 0A, 02, 08, 30, 32, 33, 34, 35, 38, 39, 40, 42, 47, 54, 59, 72, 3A, 3C, 3E, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 4F, 4G, 5X, 7X, 8P	$ 88.96
Disabled	20, 24, 26, 28, 36, 60, 64, 66, 68, 6A, 6C, 6N, 6P, 6R	$ 203.17
Aged	10, 14, 16, 18	$ 146.29
Child	03, 04, 4A, 4C, 4K, 5K, 45, 82, 7A, 8R	$ 86.53
Adult	86	$ 917.28
AIDS Beneficiary		$ 770.92

2. 5.4 CAPITATION RATES CONSTITUTE PAYMENT IN FULL

Capitation rates for each rate period, as calculated by DHS, are prospective rates and constitute payment in full, subject to any stop loss reinsurance provisions, on behalf of a Member for all Covered Services required by such Member and for all administrative costs incurred by the Contractor in providing or arranging for such services, and subject to adjustments for federally qualified health centers in accordance with Section 14087.325 of the W&I Code, but do not include payment for recoupment of current or previous losses incurred by Contractor. DHS is not responsible for making payments for recoupment of losses. The actuarial basis for the determination of the capitation payment rates is outlined in Attachment 1 (consisting of 12 pages).

3. All other terms, conditions, and provisions contained in Sections 5.3 and 5.4 remain unchanged.

Plan Name: Molina Medical Center
County: Riverside
Plan #: Commercial Plan
Aid Code Grouping: Family
Plan Type: 355

Date: 03-Nov-00

The Rate Period is August 1, 2000 to September 30, 2000

Capitation Payments at the End of the Month

Coverage Adjustments

Service	Coverage
CCS Indicated Claims	NOT Covered by the Plan
Mental Health Outpatient Services	NOT Covered by the Plan
Mental Health Pharmacy Costs	NOT Covered by the Plan
Mental Health Hospital Inpatient Services	NOT Covered by the Plan
Eyewear	NOT Covered by the Plan
Heroin Detoxification	NOT Covered by the Plan
AIDS Waiver Services	NOT Covered by the Plan
Adult Day Health Care	NOT Covered by the Plan
Chiropractor/Acupuncture	NOT Covered by the Plan
Local Education Authority	NOT Covered by the Plan
Alphafeto Protein Testing	NOT Covered by the Plan
Long Term Care for month of entry plus one	Covered by the Plan
Long Term Care after month of entry plus one	NOT Covered by the Plan
Special AIDS drugs	NOT Covered by the Plan

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	Total
1. Average Cost Per Unit	$ 66.25	$ 23.82	$ 864.71	$ 20.37	$ 229.41	$ 8.79	
2. Units per Eligible	5.957	3.361	0.304	2.609	0.009	6.410	
Cost per Elig. per Mo.	$ 32.89	$ 6.67	$ 21.91	$ 4.43	$ 0.17	$ 4.70	$ 70.77
Adjustments							
a. Demographics	0.883	0.875	0.853	0.903	1.000	0.866	
b. Area	1.008	1.000	1.000	1.000	1.000	1.000	
c. Coverages	0.975	0.992	0.968	0.956	0.995	0.868	
d. Interest	1.000	1.000	1.000	1.000	1.000	1.000	
Adjusted Base Cost	$ 28.55	$ 5.79	$ 18.09	$ 3.82	$ 0.17	$ 3.53	$ 59.95
3. Legislative Adjs.	1.280	0.975	1.012	1.034	1.159	1.094	
4. Trend Adjustments							
a. Cost per Unit	1.000	1.100	1.000	1.000	1.000	1.000	
b. Units per Eligible	1.000	0.998	1.045	1.000	1.000	1.100	
Projected Cost per Eligible	$ 36.54	$ 6.20	$ 19.13	$ 3.95	$ 0.20	$ 4.25	$ 70.27
5. Stop Loss Rein.	Amount		$ 0		Rate	0.0%	0.00
6. CHDP							4.88
7. Fee-for-Service Adj.						13.0%	9.13
Capitation Rate							$ 84.28
Value of Provider Rate Increase							$ 4.67

Prepared by Department of Health Services, Rate Development Branch

Plan Name: Molina Medical Center
County: Riverside   Plan # : Commercial Plan
Aid Code Grouping: Disabled   Plan Type: 355

Date: 03-Nov-00
Base Period: FY 96/97

The Rate Period is August 1, 2000 to September 30, 2000

Capitation Payments at the End of the Month

Coverage Adjustments

CCS Indicated Claims	NOT Covered by the Plan
Mental Health Outpatient Services	NOT Covered by the Plan
Mental Health Pharmacy Costs	NOT Covered by the Plan
Mental Health Hospital Inpatient Services	NOT Covered by the Plan
Eyewear	NOT Covered by the Plan
Heroin Detoxification	NOT Covered by the Plan
AIDS Waiver Services	NOT Covered by the Plan
Adult Day Health Care	NOT Covered by the Plan
Chiropractor/Acupuncture	NOT Covered by the Plan
Local Education Authority	NOT Covered by the Plan
Alphafeto Protein Testing	NOT Covered by the Plan
Long Term Care for month of entry plus one	Covered by the Plan
Long Term Care after month of entry plus one	NOT Covered by the Plan
Special AIDS drugs	NOT Covered by the Plan

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	Total
1. Average Cost Per Unit	$ 20.15	$ 50.42	$ 485.15	$ 18.26	$ 184.85	$ 7.07	
2. Units per Eligible	13.720	21.892	1.011	6.029	0.452	63.930	
Cost per Elig. per Mo.	$ 23.04	$ 91.98	$ 40.87	$ 9.17	$ 6.96	$ 37.67	$ 209.69
Adjustments							
a. Demographics	1.027	0.895	0.946	1.076	0.937	1.053	
b. Area	1.008	1.000	1.000	1.000	1.000	1.000	
c. Coverages	0.900	0.875	0.920	0.973	0.995	0.877	
d. Interest	1.000	1.000	1.000	1.000	1.000	1.000	
Adjusted Base Cost	$ 21.47	$ 72.03	$ 35.57	$ 9.60	$ 6.49	$ 34.79	$ 179.95
3. Legislative Adjs.	1.123	0.920	0.933	1.035	1.159	0.979	
4. Trend Adjustments							
a. Cost per Unit	1.000	1.100	1.100	1.000	1.000	1.000	
b. Units per Eligible	1.050	0.998	0.903	0.950	1.000	1.100	
Projected Cost per Eligible	$ 25.32	$ 72.75	$ 32.96	$ 9.44	$ 7.52	$ 37.47	185.46
5. Stop Loss Reins.		Amount	$ 0		Rate	0.0%	0.00
6. CHDP							0.00
7. Fee-for-Service Adj.						11.0%	20.40
Capitation Rate							205.86
Value of Provider Rate Increase							4.84

Prepared by Department of Health Services, Rate Development Branch

Plan Name: Molina Medical Center
County: Riverside Plan #: Commercial Plan
Aid Code Grouping: Aged Plan Type: 355

Date: 03-Nov-00
Base Period: 96/97

The Rate Period is August 1, 2000 to September 30, 2000

Capitation Payments at the End of the Month

Coverage Adjustments

Service	Coverage
CCS Indicated Claims	NOT Covered by the Plan
Mental Health Outpatient Services	NOT Covered by the Plan
Mental Health Pharmacy Costs	NOT Covered by the Plan
Mental Health Hospital Inpatient Services	NOT Covered by the Plan
Eyewear	NOT Covered by the Plan
Heroin Detoxification	NOT Covered by the Plan
AIDS Waiver Services	NOT Covered by the Plan
Adult Day Health Care	NOT Covered by the Plan
Chiropractor/Acupuncture	NOT Covered by the Plan
Local Education Authority	NOT Covered by the Plan
Alphafeto Protein Testing	NOT Covered by the Plan
Long Term Care for month of entry plus one	Covered by the Plan
Long Term Care after month of entry plus one	NOT Covered by the Plan
Special AIDS drugs	NOT Covered by the Plan

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	Total
1. Average Cost Per Unit	$ 16.06	$ 38.28	$ 287.24	$ 11.67	$ 177.26	$ 6.49	
2. Units per Eligible	11.563	16.963	0.819	3.904	1.049	42.784	
Cost per Elig. per Mo.	$ 15.48	$ 54.11	$ 19.60	$ 3.80	$ 15.50	$ 23.14	$ 131.63
Adjustments							
a. Demographics	0.953	1.025	0.958	0.968	1.035	1.021	
b. Area	1.008	1.000	1.000	1.000	1.000	1.000	
c. Coverages	0.981	0.996	0.997	0.986	0.997	0.781	
d. Interest	1.000	1.000	1.000	1.000	1.000	1.000	
Adjusted Base Cost	$ 14.59	$ 55.24	$ 18.72	$ 3.63	$ 15.99	$ 18.45	$ 126.62
3. Legislative Adjs.	0.968	0.920	0.940	1.035	1.159	0.954	
4. Trend Adjustments							
a. Cost per Unit	1.000	1.100	1.100	1.000	1.000	1.000	
b. Units per Eligible	1.050	0.998	0.950	1.045	0.950	1.100	
Projected Cost per Eligible	$ 14.83	$ 55.79	$ 18.39	$ 3.93	$ 17.61	$ 19.36	129.91
5. Stop Loss Rein.	Amount		$ 0		Rate	0.0%	0.00
6. CHDP							0.00
7. Fee-for-Service Adj.						11.0%	14.29
Capitation Rate							144.20
Value of Provider Rate Increase							0.78

Prepared by Department of Health Services, Rate Development Branch

Plan Name: Molina Medical Center
County: Riverside — Plan #: Commercial Plan
Aid Code Grouping: Child — Plan Type: 355

Date: 03-Nov-00

Base Period: FY 96/97

The Rate Period is August 1, 2000 to September 30, 2000

Capitation Payments at the End of the Month

Coverage Adjustments

Service	Coverage
CCS Indicated Claims	NOT Covered by the Plan
Mental Health Outpatient Services	NOT Covered by the Plan
Mental Health Pharmacy Costs	NOT Covered by the Plan
Mental Health Hospital Inpatient Services	NOT Covered by the Plan
Eyewear	NOT Covered by the Plan
Heroin Detoxification	NOT Covered by the Plan
AIDS Waiver Services	NOT Covered by the Plan
Adult Day Health Care	NOT Covered by the Plan
Chiropractor/Acupuncture	NOT Covered by the Plan
Local Education Authority	NOT Covered by the Plan
Alphafeto Protein Testing	NOT Covered by the Plan
Long Term Care for month of entry plus one	Covered by the Plan
Long Term Care after month of entry plus one	NOT Covered by the Plan
Special AIDS drugs	NOT Covered by the Plan

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	Total
1. Average Cost Per Unit	$ 58.40	$ 17.50	$ 889.41	$ 18.79	$ 140.26	$ 6.45	
2. Units per Eligible	5.196	3.068	0.436	2.787	0.019	10.564	
Cost per Elig. per Mo.	$ 25.29	$ 4.47	$ 32.32	$ 4.36	$ 0.22	$ 5.68	$ 72.34
Adjustments							
a. Demographics	1.156	1.020	1.155	1.139	1.000	1.048	
b. Area	1.008	1.000	1.000	1.000	1.000	1.000	
c. Coverages	0.974	0.984	0.952	0.973	0.996	0.882	
d. Interest	1.000	1.000	1.000	1.000	1.000	1.000	
Adjusted Base Cost	$ 28.71	$ 4.49	$ 35.54	$ 4.83	$ 0.22	$ 5.25	$ 79.04
3. Legislative Adjs.	1.175	1.055	1.019	1.034	1.159	1.102	
4. Trend Adjustments							
a. Cost per Unit	1.000	1.100	1.000	1.000	1.000	1.000	
b. Units per Eligible	1.000	0.998	1.045	1.000	1.000	1.100	
Projected Cost per Eligible	$ 33.73	$ 5.20	$ 37.84	$ 4.99	$ 0.25	$ 6.36	88.37
5. Stop Loss Reins.	Amount		$ 0		Rate	0.0%	0.00
6. CHDP							4.06
7. Fee-for-Service Adj.						11.0%	9.72
Capitation Rate							102.15
Value of Provider Rate Increase							0.84

Prepared by Department of Health Services, Rate Development Branch

Plan Name: Molina Medical Center
County: Riverside Plan #: Commercial Plan
Aid Code Grouping: Adult Plan Type: 355

Date: 03-Nov-00
Base Period: FY 96/97

The Rate Period is August 1, 2000 to September 30, 2000

Capitation Payments at the End of the Month

Coverage Adjustments

Coverage	Status
CCS Indicated Claims	NOT Covered by the Plan
Mental Health Outpatient Services	NOT Covered by the Plan
Mental Health Pharmacy Costs	NOT Covered by the Plan
Mental Health Hospital Inpatient Services	NOT Covered by the Plan
Eyewear	NOT Covered by the Plan
Heroin Detoxification	NOT Covered by the Plan
AIDS Waiver Services	NOT Covered by the Plan
Adult Day Health Care	NOT Covered by the Plan
Chiropractor/Acupuncture	NOT Covered by the Plan
Local Education Authority	NOT Covered by the Plan
Alphafeto Protein Testing	NOT Covered by the Plan
Long Term Care for month of entry plus one	Covered by the Plan
Long Term Care after month of entry plus one	NOT Covered by the Plan
Special AIDS drugs	NOT Covered by the Plan

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	Total
1. Average Cost Per Unit	$ 164.23	$ 19.84	$ 964.66	$ 19.73	$ 0.00	$ 30.86	
2. Units per Eligible	22.157	4.314	4.387	17.657	0.000	8.468	
Cost per Elig. per Mo.	$ 303.24	$ 7.13	$ 352.66	$ 29.03	$ 0.00	$ 21.78	$ 713.84
Adjustments							
a. Demographics	1.000	1.000	1.000	1.000	1.000	1.000	
b. Area	1.008	1.000	1.000	1.000	1.000	1.000	
c. Coverages	0.999	0.999	0.999	0.989	1.000	0.887	
d. Interest	1.000	1.000	1.000	1.000	1.000	1.000	
Adjusted Base Cost	$ 305.43	$ 7.12	$ 352.31	$ 28.71	$ 0.00	$ 19.32	$ 712.89
3. Legislative Adjs.	1.067	0.945	1.011	1.034	1.159	1.093	
4. Trend Adjustments							
a. Cost per Unit	1.000	1.100	1.000	1.000	1.000	1.000	
b. Units per Eligible	1.000	0.998	1.045	1.000	1.000	1.100	
Projected Cost per Eligible	$ 325.89	$ 7.39	$ 372.21	$ 29.69	$ 0.00	$ 23.23	758.41
5. Stop Loss Reins.	Amount		$ 0		Rate	0.0%	0.00
6. CHDP							0.00
7. Fee-for-Service Adj.						11.0%	83.43
Capitation Rate							841.84
Value of Provider Rate Increase							3.24

Prepared by Department of Health Services, Rate Development Branch

Plan Name: Molina Medical Center
County: Riverside
Aid Code Grouping: AIDS
Plan #: Commercial Plan
Plan Type: 355

Date: 03-Nov-00
Base Period: FY 96/97

The Rate Period is August 1, 2000 to September 30, 2000

Capitation Payments at the End of the Month

Coverage Adjustments

Service	Coverage
CCS Indicated Claims	NOT Covered by the Plan
Mental Health Outpatient Services	NOT Covered by the Plan
Mental Health Pharmacy Costs	NOT Covered by the Plan
Mental Health Hospital Inpatient Services	NOT Covered by the Plan
Eyewear	NOT Covered by the Plan
Heroin Detoxification	NOT Covered by the Plan
AIDS Waiver Services	NOT Covered by the Plan
Adult Day Health Care	NOT Covered by the Plan
Chiropractor/Acupuncture	NOT Covered by the Plan
Local Education Authority	NOT Covered by the Plan
Alphafeto Protein Testing	NOT Covered by the Plan
Long Term Care for month of entry plus one	Covered by the Plan
Long Term Care after month of entry plus one	NOT Covered by the Plan
Special AIDS drugs	NOT Covered by the Plan

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	Total
1. Average Cost Per Unit	$ 25.87	$ 141.75	$ 485.15	$ 17.75	$ 228.06	$ 14.00	
2. Units per Eligible	29.254	46.897	3.823	28.506	0.450	78.563	
Cost per Elig. per Mo.	$ 63.07	$ 553.97	$ 154.56	$ 42.17	$ 8.55	$ 91.66	$ 913.98
Adjustments							
a. Demographics	1.000	1.000	1.000	1.000	1.000	1.000	
b. Area	1.008	1.000	1.000	1.000	1.000	1.000	
c. Coverages	0.918	0.648	0.957	0.992	0.998	0.642	
d. Interest	1.000	1.000	1.000	1.000	1.000	1.000	
Adjusted Base Cost	$ 58.37	$ 358.97	$ 147.91	$ 41.83	$ 8.53	$ 58.85	$ 674.46
3. Legislative Adjs.	1.082	0.843	0.981	1.009	1.159	0.995	
4. Trend Adjustments							
a. Cost per Unit	1.000	1.100	1.100	1.000	1.000	1.000	
b. Units per Eligible	1.050	0.998	0.903	0.950	1.000	1.100	
Projected Cost per Eligible	$ 66.31	$ 332.21	$ 144.13	$ 40.10	$ 9.89	$ 64.41	657.05
5. Stop Loss Reins.	Amount		$ 0		Rate	0.0%	0.00
6. CHDP							0.00
7. Fee-for-Service Adj.						11.0%	72.28
Capitation Rate							729.33
Value of Provider Rate Increase							7.23

Prepared by Department of Health Services, Rate Development Branch

Plan Name: Molina Medical Center
County: San Bernadino Plan #: Commercial Plan
Aid Code Grouping: Family Plan Type: 356

Date: 03-Nov-00
Base Period: FY 96/97

The Rate Period is August 1, 2000 to September 30, 2000

Capitation Payments at the End of the Month

Coverage Adjustments

CCS Indicated Claims	NOT Covered by the Plan
Mental Health Outpatient Services	NOT Covered by the Plan
Mental Health Pharmacy Costs	NOT Covered by the Plan
Mental Health Hospital Inpatient Services	NOT Covered by the Plan
Eyewear	NOT Covered by the Plan
Heroin Detoxification	NOT Covered by the Plan
AIDS Waiver Services	NOT Covered by the Plan
Adult Day Health Care	NOT Covered by the Plan
Chiropractor/Acupuncture	NOT Covered by the Plan
Local Education Authority	NOT Covered by the Plan
Alphafeto Protein Testing	NOT Covered by the Plan
Long Term Care for month of entry plus one	Covered by the Plan
Long Term Care after month of entry plus one	NOT Covered by the Plan
Special AIDS drugs	NOT Covered by the Plan

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	Total
1. Average Cost Per Unit	$ 66.25	$ 23.82	$ 978.02	$ 20.37	$ 229.41	$ 8.79	
2. Units per Eligible	5.957	3.361	0.304	2.609	0.009	6.410	
Cost per Elig. per Mo.	$ 32.89	$ 6.67	$ 24.78	$ 4.43	$ 0.17	$ 4.70	$ 73.64
Adjustments							
a. Demographics	0.829	0.863	0.714	0.835	1.000	0.871	
b. Area	1.008	1.000	1.000	1.000	1.000	1.000	
c. Coverages	0.975	0.992	0.968	0.956	0.995	0.868	
d. Interest	1.000	1.000	1.000	1.000	1.000	1.000	
Adjusted Base Cost	$ 26.80	$ 5.71	$ 17.13	$ 3.54	$ 0.17	$ 3.55	$ 56.90
3. Legislative Adjs.	1.280	0.975	1.012	1.034	1.159	1.094	
4. Trend Adjustments							
a. Cost per Unit	1.000	1.100	1.000	1.000	1.000	1.000	
b. Units per Eligible	1.000	0.998	1.045	1.000	1.000	1.100	
Projected Cost per Eligible	$ 34.30	$ 6.11	$ 18.12	$ 3.66	$ 0.20	$ 4.27	66.66
5. Stop Loss Reins.	Amount		$ 0		Rate	0.0%	0.00
6. CHDP							4.88
7. Fee-for-Service Adj.						26.1%	17.42
Capitation Rate							88.96
Value of Provider Rate Increase							4.89

Prepared by Department of Health Services, Rate Development Branch

Plan Name: Molina Medical Center
County: San Bernardino   Plan #: Commercial Plan
Aid Code Grouping: Disabled   Plan Type: 356

Date: 03-Nov-00
Base Period : FY 96/97
The Rate Period is August 1, 2000 to September 30, 2000

Capitation Payments at the End of the Month

Coverage Adjustments

Service	Coverage
CCS Indicated Claims	NOT Covered by the Plan
Mental Health Outpatient Services	NOT Covered by the Plan
Mental Health Pharmacy Costs	NOT Covered by the Plan
Mental Health Hospital Inpatient Services	NOT Covered by the Plan
Eyewear	NOT Covered by the Plan
Heroin Detoxification	NOT Covered by the Plan
AIDS Waiver Services	NOT Covered by the Plan
Adult Day Health Care	NOT Covered by the Plan
Chiropractor/Acupuncture	NOT Covered by the Plan
Local Education Authority	NOT Covered by the Plan
Alphafeto Protein Testing	NOT Covered by the Plan
Long Term Care for month of entry plus one	Covered by the Plan
Long Term Care after month of entry plus one	NOT Covered by the Plan
Special AIDS drugs	NOT Covered by the Plan

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	Total
1. Average Cost Per Unit	$ 20.15	$ 50.42	$ 611.26	$ 18.26	$ 184.85	$ 7.07	
2. Units per Eligible	13.720	21.892	1.011	6.029	0.452	63.930	
Cost per Elig. per Mo.	$ 23.04	$ 91.98	$ 51.50	$ 9.17	$ 6.96	$ 37.67	$ 220.32
Adjustments							
a. Demographics	0.942	0.851	0.850	1.019	0.995	1.023	
b. Area	1.008	1.000	1.000	1.000	1.000	1.000	
c. Coverages	0.900	0.875	0.920	0.973	0.995	0.877	
d. Interest	1.000	1.000	1.000	1.000	1.000	1.000	
Adjusted Base Cost	$ 19.69	$ 68.49	$ 40.27	$ 9.09	$ 6.89	$ 33.80	$ 178.23
3. Legislative Adjs	1.123	0.920	0.933	1.035	1.159	0.979	
4. Trend Adjustments							
a. Cost per Unit	1.000	1.100	1.100	1.000	1.000	1.000	
b. Units per Eligible	1.050	0.998	0.903	0.950	1.000	1.100	
Projected Cost per Eligible	$ 23.22	$ 69.17	$ 37.32	$ 8.94	$ 7.99	$ 36.40	183.04
5. Stop Loss Reins.	Amount		$ 0		Rate	0.0%	0.00
6. CHDP							0.00
7. Fee-for-Service Adj.						11.0%	20.13
Capitation Rate							203.17
Value of Provider Rate Increase							4.49

Prepared by Department of Health Services, Rate Development Branch

Plan Name: Molina Medical Center
County: San Bernardino Plan #: Commercial Plan
Aid Code Grouping: Aged Plan Type: 356

Date: 03-Nov-00
Base Period: FY 96/97

The Rate Period is August 1, 2000 to September 30, 2000

Capitation Payments at the End of the Month

Coverage Adjustments

Service	Coverage
CCS Indicated Claims	NOT Covered by the Plan
Mental Health Outpatient Services	NOT Covered by the Plan
Mental Health Pharmacy Costs	NOT Covered by the Plan
Mental Health Hospital Inpatient Services	NOT Covered by the Plan
Eyewear	NOT Covered by the Plan
Heroin Detoxification	NOT Covered by the Plan
AIDS Waiver Services	NOT Covered by the Plan
Adult Day Health Care	NOT Covered by the Plan
Chiropractor/Acupuncture	NOT Covered by the Plan
Local Education Authority	NOT Covered by the Plan
Alphafeto Protein Testing	NOT Covered by the Plan
Long Term Care for month of entry plus one	Covered by the Plan
Long Term Care after month of entry plus one	NOT Covered by the Plan
Special AIDS drugs	NOT Covered by the Plan

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	Total
1. Average Cost Per Unit	$ 16.06	$ 38.28	$ 316.16	$ 11.67	$ 117.26	$ 6.49	
2. Units per Eligible	11.563	16.963	0.819	3.904	1.049	42.784	
Cost per Elig. per Mo.	$ 15.48	$ 54.11	$ 21.58	$ 3.60	$ 15.50	$ 23.14	$ 133.61
Adjustments							
a. Demographics	0.964	1.019	0.964	0.963	1.034	1.022	
b. Area	1.008	1.000	1.000	1.000	1.000	1.000	
c. Coverages	0.981	0.996	0.997	0.986	0.997	0.781	
d. Interest	1.000	1.000	1.000	1.000	1.000	1.000	
Adjusted Base Cost	$ 14.76	$ 54.92	$ 20.74	$ 3.68	$ 15.98	$ 18.47	$ 128.55
3. Legislative Adjs	0.968	0.920	0.940	1.035	1.159	0.954	
4. Trend Adjustments							
a. Cost per Unit	1.000	1.100	1.100	1.000	1.000	1.000	
b. Units per Eligible	1.050	0.998	0.950	1.045	0.950	1.100	
Projected Cost per Eligible	$ 15.00	$ 55.47	$ 20.37	$ 3.98	$ 17.59	$ 19.38	131.79
5. Stop Loss Reins.	Amount		$ 0		Rate	0.0%	0.00
6. CHDP							0.00
7. Fee-for-Service Adj.						11.0%	14.50
Capitation Rate							146.29
Value of Provider Rate Increase							0.77

Prepared by Department of Health Services, Rate Development Branch

Plan Name: Molina Medical Center
County: San Bernardino   Plan #: Commercial Plan
Aid Code Grouping: Child   Plan Type: 356

Date: 03-Nov-00
Base Period: FY 96/97

The Rate Period is August 1, 2000 to September 30, 2000

Capitation Payments at the End of the Month

Coverage Adjustments

Service	Coverage
CCS Indicated Claims	NOT Covered by the Plan
Mental Health Outpatient Services	NOT Covered by the Plan
Mental Health Pharmacy Costs	NOT Covered by the Plan
Mental Health Hospital Inpatient Services	NOT Covered by the Plan
Eyewear	NOT Covered by the Plan
Heroin Detoxification	NOT Covered by the Plan
AIDS Waiver Services	NOT Covered by the Plan
Adult Day Health Care	NOT Covered by the Plan
Chiropractor/Acupuncture	NOT Covered by the Plan
Local Education Authority	NOT Covered by the Plan
Alphafeto Protein Testing	NOT Covered by the Plan
Long Term Care for month of entry plus one	Covered by the Plan
Long Term Care after month of entry plus one	NOT Covered by the Plan
Special AIDS drugs	NOT Covered by the Plan

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	Total
1. Average Cost Per Unit	$ 58.40	$ 17.50	$ 1,120.53	$ 18.79	$ 140.26	$ 6.45	
2. Units per Eligible.	5.196	3.068	0.436	2.787	0.019	10.564	
Cost per Elig. per Mo	$ 25.29	$ 4.47	$ 40.71	$ 4.36	$ 0.22	$ 5.68	$ 80.73
Adjustments							
a. Demographics	0.927	0.989	0.788	0.935	1.000	0.946	
b. Area	1.008	1.000	1.000	1.000	1.000	1.000	
c. Coverages	0.974	0.984	0.952	0.973	0.996	0.882	
d. Interest	1.000	1.000	1.000	1.000	1.000	1.000	
Adjusted Base Cost	$ 23.02	$ 4.35	$ 30.15	$ 3.97	$ 0.22	$ 4.74	$ 66.45
3. Legislative Adjs.	1.175	1.055	1.019	1.034	1.159	1.102	
4. Trend Adjustments							
a. Cost per Unit	1.000	1.100	1.000	1.000	1.000	1.000	
b. Units per Eligible	1.000	0.998	1.045	1.000	1.000	1.100	
Projected Cost per Eligible	$ 27.05	$ 5.04	$ 32.11	$ 4.10	$ 0.25	$ 5.75	74.30
5. Stop Loss Reins.	Amount		$ 0		Rate	0.0%	0.00
6. CHDP							4.06
7. Fee-for-Service Adj.						11.0%	8.17
Capitation Rate							86.53
Value of Provider Rate Increase							0.71

Prepared by Department of Health Services, Rate Development Branch

Plan Name: Molina Medical Center
County: San Bernardino Plan #: Commercial Plan
Aid Code Grouping: Adult Plan Type: 356

Date: 03-Nov-00
Base Period: FY 96/97

The Rate Period is August 1, 2000 to September 30, 2000

Capitation Payments at the End of the Month

Coverage Adjustments

Coverage	Status
CCS Indicated Claims	NOT Covered by the Plan
Mental Health Outpatient Services	NOT Covered by the Plan
Mental Health Pharmacy Costs	NOT Covered by the Plan
Mental Health Hospital Inpatient Services	NOT Covered by the Plan
Eyewear	NOT Covered by the Plan
Heroin Detoxification	NOT Covered by the Plan
AIDS Waiver Services	NOT Covered by the Plan
Adult Day Health Care	NOT Covered by the Plan
Chiropractor/Acupuncture	NOT Covered by the Plan
Local Education Authority	NOT Covered by the Plan
Alphafeto Protein Testing	NOT Covered by the Plan
Long Term Care for month of entry plus one	Covered by the Plan
Long Term Care after month of entry plus one	NOT Covered by the Plan
Special AIDS drugs	NOT Covered by the Plan

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	Total
1. Average Cost Per Unit	$ 164.23	$ 19.84	$ 1,140.81	$ 19.73	$ 0.00	$ 30.86	
2. Units per Eligible	22.157	4.314	4.387	17.657	0.000	8.468	
Cost per Elig. per Mo.	$ 303.24	$ 7.13	$ 417.06	$ 29.03	$ 0.00	$ 21.78	$ 778.24
Adjustments							
a. Demographics	1.000	1.000	1.000	1.000	1.000	1.000	
b. Area	1.008	1.000	1.000	1.000	1.000	1.000	
c. Coverages	0.999	0.999	0.999	0.989	1.000	0.887	
d. Interest	1.000	1.000	1.000	1.000	1.000	1.000	
Adjusted Base Cost	$ 305.43	$ 7.12	$ 416.64	$ 28.71	$ 0.00	$ 19.32	$ 777.22
3. Legislative Adjs.	1.067	0.945	1.011	1.034	1.159	1.093	
4. Trend Adjustments							
a. Cost per Unit	1.000	1.100	1.000	1.000	1.000	1.000	
b. Units per Eligible	1.000	0.998	1.045	1.000	1.000	1.100	
Projected Cost per Eligible	$ 325.89	$ 7.39	$ 440.18	$ 29.69	$ 0.00	$ 23.23	826.38
5. Stop Loss Rein		Amount	$ 0		Rate	0.0%	0.00
6. CHDP							0.00
7. Fee-for-Service Adj.						11.0%	90.90
Capitation Rate							917.28
Value of Provider Rate Increase							3.23

Prepared by Department of Health Services, Rate Development Branch

Plan Name: Molina Medical Center
County: San Bernardino Plan #: Commercial Plan
Aid Code Grouping: AIDS Plan Type: 356

Date: 03-Nov-00
Base Period: FY 96/97

The Rate Period is August 1, 2000 to September 30, 2000

Capitation Payments at the End of the Month

Coverage Adjustments

Coverage	Status
CCS Indicated Claims	NOT Covered by the Plan
Mental Health Outpatient Services	NOT Covered by the Plan
Mental Health Pharmacy Costs	NOT Covered by the Plan
Mental Health Hospital Inpatient Services	NOT Covered by the Plan
Eyewear	NOT Covered by the Plan
Heroin Detoxification	NOT Covered by the Plan
AIDS Waiver Services	NOT Covered by the Plan
Adult Day Health Care	NOT Covered by the Plan
Chiropractor/Acupuncture	NOT Covered by the Plan
Local Education Authority	NOT Covered by the Plan
Alphafeto Protein Testing	NOT Covered by the Plan
Long Term Care for month of entry plus one	Covered by the Plan
Long Term Care after month of entry plus one	NOT Covered by the Plan
Special AIDS drugs	NOT Covered by the Plan

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	Total
1. Average Cost Per Unit	$ 25.87	$ 141.75	$ 611.26	$ 17.75	$ 228.06	$ 14.00	
2. Units per Eligible	29.254	46.897	3.823	28.506	0.450	78.563	
Cost per Elig. per Mo.	$ 63.07	$ 553.97	$ 194.74	$ 42.17	$ 8.55	$ 91.66	$ 954.16
Adjustments							
a. Demographics	1.000	1.000	1.000	1.000	1.000	1.000	
b. Area	1.008	1.000	1.000	1.000	1.000	1.000	
c. Coverages	0.918	0.648	0.957	0.992	0.998	0.642	
d. Interest	1.000	1.000	1.000	1.000	1.000	1.000	
Adjusted Base Cost	$ 58.37	$ 358.97	$ 186.37	$ 41.83	$ 8.53	$ 58.85	$ 712.92
3. Legislative Adjs	1.082	0.843	0.981	1.009	1.159	0.995	
4. Trend Adjustments							
a. Cost per Unit	1.000	1.100	1.100	1.000	1.000	1.000	
b. Units per Eligible	1.050	0.998	0.903	0.950	1.000	1.100	
Projected Cost per Eligible	$ 66.31	$ 332.21	$ 181.60	$ 40.10	$ 9.89	$ 64.41	694.52
5. Stop Loss Reins.		Amount	$ 0		Rate	0.0%	0.00
6. CHDP							0.00
7. Fee-for-Service Adj.						11.0%	76.40
Capitation Rate							770.92
Value of Provider Rate Increase							7.23

Prepared by Department of Health Services, Rate Development Branch

[LETTER HEAD OF DEPARTMENT OF HEALTH SERVICES]

October 30, 2001

Mr. George Goldstein
CEO
Molina Healthcare of California
dba: Molina
One Golden Shore Dr.
Long Beach, CA 90802

Dear Mr. Goldstein:

In accordance with Article V, Section 5.5 of your Contract, the enclosed Change Order No. 10 transmits (Molina Health Care of California dba: Molina) annual capitation rates for the period beginning October 1, 2001 to September 30, 2002.

The retropayment, between the old rates and the new 2001/2002 rates for the period beginning October 1, 2001, will be processed in approximately four to six weeks.

If you have any questions, please contact your contract manager.

Sincerely,

/s/

Cheri Rice, Chief
Medi-Cal Managed Care Division

Enclosure

[LETTER HEAD OF DEPARTMENT OF HEALTH SERVICES]

CHANGE ORDER NUMBER C10 TO CONTRACT NO.95-23637: ADJUSTING THE ANNUAL CAPITATION RATE FOR PROVIDER RATE INCREASES FOR THE PERIOD OCTOBER 1, 2001 TO SEPTEMBER 30, 2002, BY CHANGING CONTRACT SECTIONS; 5.3 CAPITATION RATES; AND 5.4 CAPITATION RATES CONSTITUTE PAYMENT IN FULL. This Change Order is effective October 1, 2001.

1. 5.3 CAPITATION RATES

DHS shall remit to Contractor a capitation payment each month for each Medi-Cal Member that appears on the approved list of Members supplied to Contractor by DHS. The capitation rate shall be the amount specified in this Article. The payment period for health care services shall commence on the first day of operations, as determined by DHS. Capitation payments shall be made in accordance with the following schedule of capitation payment rates:

For the period 10/01/01 - 9/30/02		San Bernardino
Groups	Aid Codes	Rate
Family	01, OA, 02, 08, 30, 32, 33, 34, 35, 38, 39, 40, 42, 47, 54, 59, 72, 3A, 3C, 3E, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 4F, 4G, 5X, 7X, 8P	$ 87.86
Disabled	20, 24, 26, 28, 36, 60, 64, 66, 68, 6A, 6C, 6H, 6N, 6P, 6R	$ 235.58
Aged	1H, 10, 14, 16, 18	$ 172.72
Child	03, 04, 4A, 4C, 4K, 5K, 45, 82, 7A, 7J, 8R	$ 104.73
Adult	86	$ 925.69
Aids Beneficiary		$ 922.10

For the period 10/01/01 - 9/30/02		Riverside
Groups	Aid Codes	Rate
Family	01, OA, 02, 08, 30, 32, 33,34, 35,38, 39,40,42,47,54,59, 72, 3A, 3C, 3E, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 4F, 4G, 5X, 7X, 8P	$ 86.87
Disabled	20, 24, 26, 28, 36, 60, 64, 66, 68,6A,6C, 6H,6N,6P, 6R	$ 233.86
Aged	1H, 10, 14, 16, 18	$ 170.89
Child	03, 04, 4A, 4C, 4K, 5K, 45, 82, 7A, 7J, 8R	$ 97.58
Adult	86	$ 844.46
Aids Beneficiary		$ 878.16

If DHS creates a new aid code that is split or derived from an existing aid code covered under this Contract, and the aid code has a neutral revenue effect for the Contractor, then the split aid code will automatically be included in the same aid code category as is the original aid code covered under this Contract. Contractor agrees to continue providing covered services to the Members at the monthly capitation rate specified for the original aid code. DHS shall confirm all aid code splits, and the rates of payment for such new aid codes, in writing to Contractor as soon as practicable after such aid code splits occur.

2. 5.4 CAPITATION RATES CONSTITUTE PAYMENT IN FULL

Capitation rates for each rate period, as calculated by DHS, are prospective rates and constitute payment in full, subject to any stop loss reinsurance provisions, on behalf of a Member for all Covered Services required by such Member and for all administrative Costs incurred by the Contractor in providing or arranging for such services, and subject to adjustments for federally qualified health centers in accordance with Section 14087.325 of the W&I Code, but do not include payment for recoupment of current or previous losses incurred by Contractor. DHS is not responsible for making payments for recoupment of losses. The actuarial basis for the determination of the capitation payment rates is outlined in Attachment 1 (consisting of 12 pages).

3. All other terms, conditions, and provisions contained in Sections 5.3 and 5.4 remain unchanged.

Plan Name: Molina Medical Center
County: San Bernardino Plan #: 356
Aid Code Grouping: Family Plan Type: Commercial Plan

Date: 11-Oct-01

The Rate Period is October 1, 2000 to September 30, 2000

Capitation Payments at the End of the Month

Coverages (C = Covered by Plan, N = NOT Covered by Plan)

Coverage		Coverage	
CCS Indicated Claims	N	AIDS Waiver	N
GHPP	N	In Home Waiver	N
Hemodialysis	C	Model NF Waiver	N
Major Organ Transplants	N	Adult Day Health Care	N
Out-of-State	C	Newborn Hearing Screens	N
Chiropractor	N	Psychiatric Drugs	N
Local Education Authority	N	AIDS Drugs	N
Psychiatrist	N	Injections	C
Acupuncturist	N	MH - Hospital Inpatient	N
Alphafeto Protein Testing	N	MH - Outpatient Services	N
Heroin Detoxification	N	Long Term Care for month of entry plus one	C
Direct Observed Therapy	N	Long Term Care after month of entry plus one	N
Lenses for eyewear	N	CHDP	C

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	Total
1. Average Cost Per Unit	$ 66.25	$ 23.82	$ 978.02	$ 20.37	$ 229.41	$ 8.79	
2. Units per Eligible/year	5.957	3.361	0.304	2.609	0.009	6.410	
Cost per Elig. per Mo.	$ 32.89	$ 6.67	$ 24.78	$ 4.43	$ 0.17	$ 4.70	$ 73.64
3. Adjustments							
a.Age/Sex	0.916	0.943	0.875	0.919	1.000	0.955	
b.Area	0.915	1.000	1.000	1.000	1.000	1.000	
c.Coverages	0.975	0.992	0.968	0.956	0.995	0.868	
d.Interest	1.000	1.000	1.000	1.000	1.000	1.000	
Adjusted Base Cost	$ 26.88	$ 6.24	$ 20.99	$ 3.89	$ 0.17	$ 3.90	$ 62.07
4. Legislative Adjustments	1.221	0.869	1.029	1.054	1.436	1.079	
5. Trend Adjustments							
a.Cost per Unit	1.000	1.262	1.040	1.000	1.000	1.000	
b.Units per Eligible	1.000	1.180	1.066	1.000	1.000	1.148	
Projected Cost per Eligible	$ 32.82	$ 8.08	$ 23.95	$ 4.10	$ 0.24	$ 4.83	$ 74.02
6. CHDP							4.88
7. Adjustment to Pool						12.1%	8.96
Capitation Rate							$ 87.86

Prepared by Department of Health Services, Rate Development Branch

Plan Name: Molina Medical Center
County: San Bernardino   Plan #: 356
Aid Code Grouping: Disabled   Plan Type: Commercial Plan

Date: 11-Oct-01

The Rate Period is October 1, 2001 to September 30, 2002

Capitation Payments at the End of the Month

Coverages (C = Covered by Plan, N = NOT Covered by Plan)

Coverage		Coverage	
CCS Indicated Claims	N	AIDS Waiver	N
GHPP	N	In Home Waiver	N
Hemodialysis	C	Model NF Waiver	N
Major Organ Transplants	N	Adult Day Health Care	N
Out-of-State	C	Newborn Hearing Screens	N
Chiropractor	N	Psychiatric Drugs	N
Local Education Authority	N	AIDS Drugs	N
Psychiatrist	N	Injections	C
Acupuncturist	N	MH - Hospital Inpatient	N
Alphafeto Protein Testing	N	MH - Outpatient Services	N
Heroin Detoxification	N	Long Term Care for month of entry plus one	C
Direct Observed Therapy	N	Long Term Care after month of entry plus one	N
Lenses for eyewear	N	CHDP	C

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	Total
1. Average Cost Per Unit	$ 20.15	$ 50.42	$ 611.26	$ 18.26	$ 184.85	$ 7.07	
2. Units per Eligible/year	13.720	21.892	1.011	6.029	0.452	63.930	
Cost per Elig. per Mo.	$ 23.04	$ 91.98	$ 51.50	$ 9.17	$ 6.96	$ 37.67	$ 220.32
3. Adjustments							
a.Age/Sex	0.929	0.838	0.895	1.038	0.977	1.048	
b.Area	0.915	1.000	1.000	1.000	1.000	1.000	
c.Coverages	0.900	0.875	0.920	0.973	0.995	0.877	
d.Interest	1.000	1.000	1.000	1.000	1.000	1.000	
Adjusted Base Cost	$ 17.63	$ 67.44	$ 42.41	$ 9.26	$ 6.77	$ 34.62	$ 178.13
4. Legislative Adjustments	1.099	0.888	0.965	1.048	1.442	0.987	
5. Trend Adjustments							
a.Cost per Unit	1.000	1.262	1.194	1.000	1.000	1.000	
b.Units per Eligible	1.073	1.180	0.863	0.929	1.000	1.148	
Projected Cost per Eligible	$ 20.79	$ 89.18	$ 42.17	$ 9.02	$ 9.76	$ 39.23	$ 210.15
6. CHDP							0.00
7. Adjustment to Pool						12.1%	25.43
Capitation Rate							$ 235.58

Prepared by Department of Health Services, Rate Development Branch

Plan Name: Molina Medical Center
County: San Bernardino Plan #: 356
Aid Code Grouping: Aged Plan Type: Commercial Plan

Date: 11-Oct-01

The Rate Period is October 1, 2000 to September 30, 2000

Capitation Payments at the End of the Month

Coverages (C = Covered by Plan, N = NOT Covered by Plan)

CCS Indicated Claims	N	AIDS Waiver	N
GHPP	N	In Home Waiver	N
Hemodialysis	C	Model NF Waiver	N
Major Organ Transplants	N	Adult Day Health Care	N
Out-of-State	C	Newborn Hearing Screens	N
Chiropractor	N	Psychiatric Drugs	N
Local Education Authority	N	AIDS Drugs	N
Psychiatrist	N	Injections	C
Acupuncturist	N	MH - Hospital Inpatient	N
Alphafeto Protein Testing	N	MH - Outpatient Services	N
Heroin Detoxification	N	Long Term Care for month of entry plus one	C
Direct Observed Therapy	N	Long Term Care after month of entry plus one	N
Lenses for eyewear	N	CHDP	C

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	Total
1. Average Cost Per Unit	$ 16.06	$ 38.28	$ 316.16	$ 11.67	$ 177.26	$ 6.49	
2. Units per Eligible/year	11.563	16.963	0.819	3.904	1.049	42.784	
Cost per Elig. per Mo.	$ 15.48	$ 54.11	$ 21.58	$ 3.80	$ 15.50	$ 23.14	$ 133.61
3. Adjustments							
a.Age/Sex	0.995	1.007	1.003	0.992	1.021	1.005	
b.Area	0.915	1.000	1.000	1.000	1.000	1.000	
c.Coverages	0.981	0.996	0.997	0.986	0.997	0.781	
d.Interest	1.000	1.000	1.000	1.000	1.000	1.000	
Adjusted Base Cost	$ 13.83	$ 54.27	$ 21.58	$ 3.72	$ 15.78	$ 18.16	$ 127.34
4. Legislative Adjustments	0.984	0.879	0.969	1.046	1.433	0.963	
5. Trend Adjustments							
a.Cost per Unit	1.000	1.262	1.194	1.000	1.000	1.000	
b.Units per Eligible	1.073	1.180	0.929	1.066	0.929	1.148	
Projected Cost per Eligible	$ 14.60	$ 71.04	$ 23.20	$ 4.15	$ 21.01	$ 20.08	$ 154.08
6. CHDP							0.00
7. Adjustment to Pool						12.1%	18.64
Capitation Rate							$ 172.72

Prepared by Department of Health Services, Rate Development Branch

Plan Name: Molina Medical Center
County: San Bernardino Plan #: 356
Aid Code Grouping: Child Plan Type: Commercial Plan

Date: 11-Oct-01

The Rate Period is October 1, 2001 to September 30, 2002

Capitation Payments at the End of the Month

Coverages (C = Covered by Plan, N = NOT Covered by Plan)

CCS Indicated Claims	N	AIDS Waiver	N
GHPP	N	In Home Waiver	N
Hemodialysis	C	Model NF Waiver	N
Major Organ Transplants	N	Adult Day Health Care	N
Out-of-State	C	Newborn Hearing Screens	N
Chiropractor	N	Psychiatric Drugs	N
Local Education Authority	N	AIDS Drugs	N
Psychiatrist	N	Injections	C
Acupuncturist	N	MH - Hospital Inpatient	N
Alphafeto Protein Testing	N	MH - Outpatient Services	N
Heroin Detoxification	N	Long Term Care for month of entry plus one	C
Direct Observed Therapy	N	Long Term Care after month of entry plus one	N
Lenses for eyewear	N	CHDP	C

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	Total
1. Average Cost Per Unit	$ 58.40	$ 17.50	$ 1,120.53	$ 18.79	$ 140.26	$ 6.45	
2. Units per Eligible/year	5.196	3.068	0.436	2.787	0.019	10.564	
Cost per Elig. per Mo.	$ 25.29	$ 4.47	$ 40.71	$ 4.36	$ 0.22	$ 5.68	$ 80.73
3. Adjustments							
a.Age/Sex	1.062	1.056	1.029	1.067	1.000	0.997	
b.Area	0.915	1.000	1.000	1.000	1.000	1.000	
c.Coverages	0.974	0.984	0.952	0.973	0.996	0.882	
d.Interest	1.000	1.000	1.000	1.000	1.000	1.000	
Adjusted Base Cost	$ 23.94	$ 4.64	$ 39.88	$ 4.53	$ 0.22	$ 4.99	$ 78.20
4. Legislative Adjustments	1.116	0.875	1.035	1.049	1.424	1.082	
5. Trend Adjustments							
a.Cost per Unit	1.000	1.262	1.040	1.000	1.000	$ 1.000	
b.Units per Eligible	1.000	1.180	1.066	1.000	1.000	1.148	
Projected Cost per Eligible	$ 26.72	$ 6.05	$ 45.76	$ 4.75	$ 0.31	$ 6.20	$ 89.79
6. CHDP							4.08
7. Adjustment to Pool						12.1%	10.86
Capitation Rate							$ 104.73

Prepared by Department of Health Services, Rate Development Branch

Plan Name: Molina Medical Center
County: San Bernardino   Plan #: 356
Aid Code Grouping: Adult   Plan Type: Commercial Plan

Date: 11-Oct-01

The Rate Period is October 1, 2001 to September 30, 2002

Capitation Payments at the End of the Month

Coverages (C = Covered by Plan, N = NOT Covered by Plan)

Coverage		Coverage	
CCS Indicated Claims	N	AIDS Waiver	N
GHPP	N	In Home Waiver	N
Hemodialysis	C	Model NF Waiver	N
Major Organ Transplants	N	Adult Day Health Care	N
Out-of-State	C	Newborn Hearing Screens	N
Chiropractor	N	Psychiatric Drugs	N
Local Education Authority	N	AIDS Drugs	N
Psychiatrist	N	Injections	C
Acupuncturist	N	MH - Hospital Inpatient	N
Alphafeto Protein Testing	N	MH - Outpatient Services	N
Heroin Detoxification	N	Long Term Care for month of entry plus one	C
Direct Observed Therapy	N	Long Term Care after month of entry plus one	N
Lenses for eyewear	N	CHDP	C

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	Total
1. Average Cost Per Unit	$ 164.23	$ 19.84	$ 1,140.81	$ 19.73	$ 0.00	$ 30.86	
2. Units per Eligible/year	22.157	4.314	4.387	17.657	0.000	8.468	
Cost per Elig. per Mo.	$ 303.24	$ 7.13	$ 417.06	$ 29.03	$ 0.00	$ 21.78	$ 778.24
3. Adjustments							
a.Age/Sex	1.000	1.000	1.000	1.000	1.000	1.000	
b.Area	0.915	1.000	1.000	1.000	1.000	1.000	
c.Coverages	0.999	0.999	0.999	0.989	1.000	0.887	
d.Interest	1.000	1.000	1.000	1.000	1.000	1.000	
Adjusted Base Cost	$ 277.19	$ 7.12	$ 416.64	$ 28.71	$ 0.00	$ 19.32	$ 748.98
4. Legislative Adjustments	1.060	0.872	1.016	1.053	1.242	1.045	
5. Trend Adjustments							
a.Cost per Unit	1.000	1.262	1.040	1.000	1.000	$ 1.000	
b.Units per Eligible	1.000	1.180	1.066	1.000	1.000	1.148	
Projected Cost per Eligible	$ 293.82	$ 9.25	$ 469.29	$ 30.23	$ 0.00	$ 23.18	$ 825.77
6. CHDP							0.00
7. Adjustment to Pool						12.1%	99.92
Capitation Rate							$ 925.69

Prepared by Department of Health Services, Rate Development Branch

Plan Name: Molina Medical Center
County: San Bernardino Plan #: 356
Aid Code Grouping: AIDS Plan Type: Commercial Plan

Date: 11-Oct-01

The Rate Period is October 1, 2001 to September 30, 2002

Capitation Payments at the End of the Month

Coverages (C = Covered by Plan, N = NOT Covered by Plan)

Coverage		Coverage	
CCS Indicated Claims	N	AIDS Waiver	N
GHPP	N	In Home Waiver	N
Hemodialysis	C	Model NF Waiver	N
Major Organ Transplants	N	Adult Day Health Care	N
Out-of-State	C	Newborn Hearing Screens	N
Chiropractor	N	Psychiatric Drugs	N
Local Education Authority	N	AIDS Drugs	N
Psychiatrist	N	Injections	C
Acupuncturist	N	MH - Hospital Inpatient	N
Alphafeto Protein Testing	N	MH - Outpatient Services	N
Heroin Detoxification	N	Long Term Care for month of entry plus one	C
Direct Observed Therapy	N	Long Term Care after month of entry plus one	N
Lenses for eyewear	N	CHDP	C

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	Total
1. Average Cost Per Unit	$ 25.87	$ 141.75	$ 611.26	$ 17.75	$ 228.06	$ 14.00	
2. Units per Eligible/year	29.254	46.897	3.823	28.506	0.450	78.563	
Cost per Elig. per Mo.	$ 63.07	$ 553.97	$ 194.74	$ 42.17	$ 8.55	$ 91.66	$ 954.16
3. Adjustments							
a.Age/Sex	1.000	1.000	1.000	1.000	1.000	1.000	
b.Area	0.915	1.000	1.000	1.000	1.000	1.000	
c.Coverages	0.918	0.663	0.957	0.992	0.998	0.642	
d.Interest	1.000	1.000	1.000	1.000	1.000	1.000	
Adjusted Base Cost	$ 52.98	$ 367.28	$ 186.37	$ 41.83	$ 8.53	$ 58.85	$ 715.84
4. Legislative Adjustments	1.070	0.826	0.989	1.013	1.529	1.001	
5. Trend Adjustments							
a.Cost per Unit	1.000	1.262	1.194	1.000	1.000	$ 1.000	
b.Units per Eligible	1.073	1.180	0.863	1.929	1.000	1.148	
Projected Cost per Eligible	$ 60.83	$ 451.77	$ 189.93	$ 39.37	$ 13.04	$ 67.63	$ 822.57
6. CHDP							0.00
7. Adjustment to Pool						12.1%	99.53
Capitation Rate							$ 922.10

Prepared by Department of Health Services, Rate Development Branch

Plan Name: Molina Medical Center
County: Riverside Plan #: 355
Aid Code Grouping: Family Plan Type: Commercial Plan

Date: 11-Oct-01

The Rate Period is October 1, 2001 to September 30, 2002

Capitation Payments at the End of the Month

Coverages (C = Covered by Plan, N = NOT Covered by Plan)

CCS Indicated Claims	N	AIDS Waiver	N
GHPP	N	In Home Waiver	N
Hemodialysis	C	Model NF Waiver	N
Major Organ Transplants	N	Adult Day Health Care	N
Out-of-State	C	Newborn Hearing Screens	N
Chiropractor	N	Psychiatric Drugs	N
Local Education Authority	N	AIDS Drugs	N
Psychiatrist	N	Injections	C
Acupuncturist	N	MH - Hospital Inpatient	N
Alphafeto Protein Testing	N	MH - Outpatient Services	N
Heroin Detoxification	N	Long Term Care for month of entry plus one	C
Direct Observed Therapy	N	Long Term Care after month of entry plus one	N
Lenses for eyewear	N	CHDP	C

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	Total
1. Average Cost Per Unit	$ 66.25	$ 23.82	$ 864.71	$ 20.37	$ 229.41	$ 8.79	
2. Units per Eligible/year	5.957	3.361	0.304	2.609	0.009	6.410	
Cost per Elig. per Mo.	$ 32.89	$ 6.67	$ 21.91	$ 4.43	$ 0.17	$ 4.70	$ 70.77
3. Adjustments							
a.Age/Sex	0.939	0.949	0.911	0.942	1.000	0.966	
b.Area	0.915	1.000	1.000	1.000	1.000	1.000	
c.Coverages	0.975	0.992	0.968	0.956	0.995	0.868	
d.Interest	1.000	1.000	1.000	1.000	1.000	1.000	
Adjusted Base Cost	$ 27.55	$ 6.28	$ 19.32	$ 3.99	$ 0.17	$ 3.94	$ 61.25
4. Legislative Adjustments	1.221	0.869	1.029	1.054	1.436	1.079	
5. Trend Adjustments							
a.Cost per Unit	1.000	1.262	1.040	1.000	1.000	$ 1.000	
b.Units per Eligible	1.000	1.180	1.066	1.000	1.000	1.148	
Projected Cost per Eligible	$ 33.64	$ 8.13	$ 22.04	$ 4.21	$ 0.24	$ 4.88	$ 73.14
6. CHDP							4.88
7. Adjustment to Pool						12.1%	8.85
Capitation Rate							$ 86.87

Prepared by Department of Health Services, Rate Development Branch

Plan Name: Molina Medical Center
County: Riverside　Plan #: 355
Aid Code Grouping: Disabled　Plan Type: Commercial Plan

Date: 11-Oct-01

The Rate Period is October 1, 2001 to September 30, 2002

Capitation Payments at the End of the Month

Coverages (C = Covered by Plan, N = NOT Covered by Plan)

CCS Indicated Claims	N	AIDS Waiver	N
GHPP	N	In Home Waiver	N
Hemodialysis	C	Model NF Waiver	N
Major Organ Transplants	N	Adult Day Health Care	N
Out-of-State	C	Newborn Hearing Screens	N
Chiropractor	N	Psychiatric Drugs	N
Local Education Authority	N	AIDS Drugs	N
Psychiatrist	N	Injections	C
Acupuncturist	N	MH - Hospital Inpatient	N
Alphafeto Protein Testing	N	MH - Outpatient Services	N
Heroin Detoxification	N	Long Term Care for month of entry plus one	C
Direct Observed Therapy	N	Long Term Care after month of entry plus one	N
Lenses for eyewear	N	CHDP	C

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	Total
1. Average Cost Per Unit	$ 20.15	$ 50.42	$ 485.15	$ 18.26	$ 184.85	$ 7.07	
2. Units per Eligible/year	13.720	21.892	1.011	6.029	0.452	63.930	
Cost per Elig. per Mo.	$ 23.04	$ 91.98	$ 40.87	$ 9.17	$ 6.96	$ 37.67	$ 209.69
3. Adjustments							
a.Age/Sex	0.981	0.869	0.938	1.074	0.949	1.077	
b.Area	0.915	1.000	1.000	1.000	1.000	1.000	
c.Coverages	0.900	0.875	0.920	0.973	0.995	0.877	
d.Interest	1.000	1.000	1.000	1.000	1.000	1.000	
Adjusted Base Cost	$ 18.61	$ 69.94	$ 35.27	$ 9.58	$ 6.57	$ 35.58	$ 175.55
4. Legislative Adjustments	1.099	0.888	0.965	1.048	1.442	0.987	
5. Trend Adjustments							
a.Cost per Unit	1.000	1.262	1.194	1.000	1.000	$ 1.000	
b.Units per Eligible	1.073	1.180	0.863	0.929	1.000	1.148	
Projected Cost per Eligible	$ 21.95	$ 92.49	$ 35.07	$ 9.33	$ 9.47	$ 40.31	$ 208.62
6. CHDP							0.00
7. Adjustment to Pool						12.1%	25.24
Capitation Rate							$ 233.86

Prepared by Department of Health Services, Rate Development Branch

Plan Name: Molina Medical Center
County: Riverside   Plan #: 355
Aid Code Grouping: Aged   Plan Type: Commercial Plan

Date: 11-Oct-01

The Rate Period is October 1, 2001 to September 30, 2002

Capitation Payments at the End of the Month

Coverages (C = Covered by Plan, N = NOT Covered by Plan)

CCS Indicated Claims	N	AIDS Waiver	N
GHPP	N	In Home Waiver	N
Hemodialysis	C	Model NF Waiver	N
Major Organ Transplants	N	Adult Day Health Care	N
Out-of-State	C	Newborn Hearing Screens	N
Chiropractor	N	Psychiatric Drugs	N
Local Education Authority	N	AIDS Drugs	N
Psychiatrist	N	Injections	C
Acupuncturist	N	MH - Hospital Inpatient	N
Alphafeto Protein Testing	N	MH - Outpatient Services	N
Heroin Detoxification	N	Long Term Care for month of entry plus one	C
Direct Observed Therapy	N	Long Term Care after month of entry plus one	N
Lenses for eyewear	N	CHDP	C

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	Total
1. Average Cost Per Unit	$ 16.06	$ 38.28	$ 287.24	$ 11.67	$ 177.26	$ 6.49	
2. Units per Eligible/year	11.563	16.963	0.819	3.904	1.049	42.784	
Cost per Elig. per Mo.	$ 15.48	$ 54.11	$ 19.60	$ 3.80	$ 15.50	$ 23.14	$ 131.63
3. Adjustments							
a.Age/Sex	0.993	1.008	1.012	0.993	1.029	1.007	
b.Area	0.915	1.000	1.000	1.000	1.000	1.000	
c.Coverages	0.981	0.996	0.997	0.986	0.997	0.781	
d.Interest	1.000	1.000	1.000	1.000	1.000	1.000	
Adjusted Base Cost	$ 13.87	$ 54.32	$ 19.78	$ 3.72	$ 15.90	$ 18.20	$ 125.79
4. Legislative Adjustments	0.984	0.879	0.969	1.046	1.433	0.963	
5. Trend Adjustments							
a.Cost per Unit	1.000	1.262	1.194	1.000	1.000	$ 1.000	
b.Units per Eligible	1.073	1.180	0.929	1.066	0.929	1.148	
Projected Cost per Eligible	$ 14.64	$ 71.10	$ 21.26	$ 4.15	$ 21.17	$ 20.12	$ 152.44
6. CHDP							0.00
7. Adjustment to Pool						12.1%	18.45
Capitation Rate							$ 170.89

Prepared by Department of Health Services, Rate Development Branch

Plan Name: Molina Medical Center
County: Riverside   Plan #: 355
Aid Code Grouping: Child   Plan Type: Commercial Plan

Date: 11-Oct-01

The Rate Period is October 1, 2001 to September 30, 2002

Capitation Payments at the End of the Month

Coverages (C = Covered by Plan, N = NOT Covered by Plan)

Coverage		Coverage	
CCS Indicated Claims	N	AIDS Waiver	N
GHPP	N	In Home Waiver	N
Hemodialysis	C	Model NF Waiver	N
Major Organ Transplants	N	Adult Day Health Care	N
Out-of-State	C	Newborn Hearing Screens	N
Chiropractor	N	Psychiatric Drugs	N
Local Education Authority	N	AIDS Drugs	N
Psychiatrist	N	Injections	C
Acupuncturist	N	MH - Hospital Inpatient	N
Alphafeto Protein Testing	N	MH - Outpatient Services	N
Heroin Detoxification	N	Long Term Care for month of entry plus one	C
Direct Observed Therapy	N	Long Term Care after month of entry plus one	N
Lenses for eyewear	N	CHDP	C

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	Total
1. Average Cost Per Unit	$ 58.40	$ 17.50	$ 889.41	$ 18.79	$ 140.26	$ 6.45	
2. Units per Eligible/year	5.196	3.068	0.436	2.787	0.019	10.564	
Cost per Elig. per Mo.	$ 25.29	$ 4.47	$ 32.32	$ 4.36	$ 0.22	$ 5.68	$ 72.34
3. Adjustments							
a.Age/Sex	1.090	1.071	1.089	1.100	1.000	0.994	
b.Area	0.915	1.000	1.000	1.000	1.000	1.000	
c.Coverages	0.974	0.984	0.952	0.973	0.996	0.882	
d.Interest	1.000	1.000	1.000	1.000	1.000	1.000	
Adjusted Base Cost	$ 24.57	$ 4.71	$ 33.51	$ 4.67	$ 0.22	$ 4.98	$ 72.65
4. Legislative Adjustments	1.116	0.875	1.035	1.049	1.424	1.082	
5. Trend Adjustments							
a.Cost per Unit	1.000	1.262	1.040	1.000	1.000	$ 1.000	
b.Units per Eligible	1.000	1.180	1.066	1.000	1.000	1.148	
Projected Cost per Eligible	$ 27.42	$ 6.14	$ 38.45	$ 4.90	$ 0.31	$ 6.19	$ 83.41
6. CHDP							4.08
7. Adjustment to Pool						12.1%	10.09
Capitation Rate							$ 97.58

Prepared by Department of Health Services, Rate Development Branch

Plan Name: Molina Medical Center
County: Riverside   Plan #: 355
Aid Code Grouping: Aged   Plan Type: Commercial Plan

Date: 11-Oct-01

The Rate Period is October 1, 2001 to September 30, 2002

Capitation Payments at the End of the Month

Coverages (C = Covered by Plan, N = NOT Covered by Plan)

CCS Indicated Claims	N	AIDS Waiver	N
GHPP	N	In Home Waiver	N
Hemodialysis	C	Model NF Waiver	N
Major Organ Transplants	N	Adult Day Health Care	N
Out-of-State	C	Newborn Hearing Screens	N
Chiropractor	N	Psychiatric Drugs	N
Local Education Authority	N	AIDS Drugs	N
Psychiatrist	N	Injections	C
Acupuncturist	N	MH - Hospital Inpatient	N
Alphafeto Protein Testing	N	MH - Outpatient Services	N
Heroin Detoxification	N	Long Term Care for month of entry plus one	C
Direct Observed Therapy	N	Long Term Care after month of entry plus one	N
Lenses for eyewear	N	CHDP	C

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	Total
1. Average Cost Per Unit	$ 164.23	$ 19.84	$ 964.66	$ 19.73	$ 0.00	$ 30.86	
2. Units per Eligible/year	22.157	4.314	4.387	17.657	0.000	8.468	
Cost per Elig. per Mo.	$ 303.24	$ 7.13	$ 352.66	$ 29.03	$ 0.00	$ 21.78	$ 713.84
3. Adjustments							
a.Age/Sex	1.000	1.000	1.000	1.000	1.000	1.000	
b.Area	0.915	1.000	1.000	1.000	1.000	1.000	
c.Coverages	0.999	0.999	0.999	0.989	1.000	0.887	
d.Interest	1.000	1.000	1.000	1.000	1.000	1.000	
Adjusted Base Cost	$ 277.19	$ 7.12	$ 352.31	$ 28.71	$ 0.00	$ 19.32	$ 684.65
4. Legislative Adjustments	1.060	0.872	1.016	1.053	1.242	1.045	
5. Trend Adjustments							
a.Cost per Unit	1.000	1.262	1.040	1.000	1.000	$ 1.000	
b.Units per Eligible	1.000	1.180	1.066	1.000	1.000	1.148	
Projected Cost per Eligible	$ 293.82	$ 9.25	$ 396.83	$ 30.23	$ 0.00	$ 23.18	$ 753.31
6. CHDP							0.00
7. Adjustment to Pool						12.1%	91.15
Capitation Rate							$ 844.46

Prepared by Department of Health Services, Rate Development Branch

Plan Name: Molina Medical Center
County: Riverside Plan #: 355
Aid Code Grouping: AIDS Plan Type: Commercial Plan

Date: 11-Oct-01

The Rate Period is October 1, 2001 to September 30, 2002

Capitation Payments at the End of the Month

Coverages (C = Covered by Plan, N = NOT Covered by Plan)

CCS Indicated Claims	N	AIDS Waiver	N
GHPP	N	In Home Waiver	N
Hemodialysis	C	Model NF Waiver	N
Major Organ Transplants	N	Adult Day Health Care	N
Out-of-State	C	Newborn Hearing Screens	N
Chiropractor	N	Psychiatric Drugs	N
Local Education Authority	N	AIDS Drugs	N
Psychiatrist	N	Injections	C
Acupuncturist	N	MH - Hospital Inpatient	N
Alphafeto Protein Testing	N	MH - Outpatient Services	N
Heroin Detoxification	N	Long Term Care for month of entry plus one	C
Direct Observed Therapy	N	Long Term Care after month of entry plus one	N
Lenses for eyewear	N	CHDP	C

Rate Calculation	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	Total
1. Average Cost Per Unit	$ 25.87	$ 141.75	$ 485.15	$ 17.75	$ 228.06	$ 14.00	
2. Units per Eligible/year	29.254	46.897	3.823	28.506	0.450	78.563	
Cost per Elig. per Mo.	$ 63.07	$ 553.97	$ 154.56	$ 42.17	$ 8.55	$ 91.66	$ 913.98
3. Adjustments							
a.Age/Sex	1.000	1.000	1.000	1.000	1.000	1.000	
b.Area	0.915	1.000	1.000	1.000	1.000	1.000	
c.Coverages	0.918	0.663	0.957	0.992	0.998	0.642	
d.Interest	1.000	1.000	1.000	1.000	1.000	$ 1.000	
Adjusted Base Cost	$ 52.98	$ 367.28	$ 147.91	$ 41.83	$ 8.53	$ 58.85	$ 677.38
4. Legislative Adjustments	1.070	0.826	0.989	1.013	1.529	1.001	
5. Trend Adjustments							
a.Cost per Unit	1.000	1.262	1.194	1.000	1.000	$ 1.000	
b.Units per Eligible	1.073	1.180	0.863	0.929	1.000	1.148	
Projected Cost per Eligible	$ 60.83	$ 451.77	$ 150.73	$ 39.37	$ 13.04	$ 67.63	$ 783.37
6. CHDP							0.00
7. Adjustment to Pool						12.1%	94.79
Capitation Rate							$ 878.16

CONFIDENTIAL TREATMENT HAS BEEN REQUESTED FOR PORTIONS OF THIS DOCUMENT. PORTIONS FOR WHICH CONFIDENTIAL TREATMENT IS REQUESTED ARE DENOTED BY "[*]". CONFIDENTIAL INFORMATION OMITTED HAS BEEN FILED SEPARATELY WITH THE SECURITIES AND EXCHANGE COMMISSION.

EXHIBIT 10.2

HEALTH SERVICES AGREEMENT BETWEEN FOUNDATION HEALTH, A CALIFORNIA HEALTH PLAN AND MOLINA MEDICAL CENTERS

This Health Services Agreement ("Agreement") is entered into this 1st day of February, 1996, by and between Foundation Health, a California Health Plan, a California corporation ("Foundation"), and Molina Medical Centers, a California corporation ("Molina").

RECITALS

A. Foundation is a prepaid full-service health care service plan licensed under the Knox-Keene Health Care Services Plan Act of 1975, as amended (the "Knox-Keene Act").

B. Molina is also a prepaid full-service health care service plan licensed under the Knox-Keene Act, with a Medi-Cal service area defined in Addendum A (the "Molina Service Area").

C. Foundation intends to contract with the California Department of Health Services under the Medi-Cal Managed Care Program for the provision of Health Care Services to persons who enroll in the Foundation Medi-Cal Plan for Los Angeles County.

D. Molina has established staff-model facilities and contracted with a network of Participating Physicians and Participating Facilities for the rendering of Health Care Services.

E. Foundation wishes to contract with Molina for the arrangement of Health Care Services, marketing services and certain administrative services to those Medi-Cal beneficiaries residing in Los Angeles County who enroll in the Foundation Medi-Cal Plan and who select, or who are assigned by Foundation to, a Molina Participating Physician as his or her Primary Care Provider.

NOW, THEREFORE, in consideration of the promises and mutual covenants contained herein, the parties agree as follows:

ARTICLE I - DEFINITIONS

1.01 Capitation Payment - is a fixed monthly payment negotiated by the parties that is payable to Molina by Foundation for each Molina Member.

1.02 DHS - is the California Department of Health Services.

1.03 DHHS - is the United States Department of Health and Human Services.

1.04 DOC - is the California Department of Corporations.

1.05 DOJ - is the United States Department of Justice.

1.06 Eligibility List - is a list of all Molina Members to be provided by Foundation on a monthly basis to Molina.

1.07 Emergency Services - are those Health Care Services required for alleviation of severe pain or immediate diagnosis and treatment of unforeseen medical conditions, which, if not immediately diagnosed and treated, would lead to disability or death.

1.08 Foundation Enrollment Packet - The information provided by Foundation to Medi-Cal Members upon enrollment in the Medi-Cal Plan which summarizes the Foundation Medi-Cal Plan offered to Molina Members and which includes an Evidence of Coverage, Disclosure Form, and Participating Provider Directory for Los Angeles County. The Evidence of Coverage is attached hereto and incorporated herein as Addendum B, the Disclosure Form is attached hereto and incorporated herein as Addendum C, and the Participating Provider Directory is attached hereto and incorporated herein as Addendum D.

1.09 Foundation Medi-Cal Plan - is the Foundation benefit plan covering the provision of Health Care Services to Medi-Cal Members pursuant to the Medi-Cal Agreement. The benefits of the Foundation Medi-Cal Plan are set forth in the Medi-Cal Agreement.

1.10 Health Care Services - are all medical, hospital and ancillary services, including Emergency Services, which are covered benefits under the Foundation Medi-Cal Plan.

1.11 Knox-Keene Act - is the Knox-Keene Health Care Service Plan Act of 1975, as amended, and the rules and regulations promulgated by DOC thereunder.

1.12 Medi-Cal - is a federal and state funded health care program established by Title XIX of the Social Security Act, as amended, which is administered in California by the DHS.

1.13 Medi-Cal Agreement - is the agreement to be entered into by and between Foundation and DHS pursuant to the Waxman-Duffy Act, under which Foundation will agree to provide health benefits under the Medi-Cal Managed Care Program to Los Angeles County Medi-Cal beneficiaries who enroll in the Foundation Medi-Cal Plan. A copy of the Medi-Cal Agreement will be provided to Molina by Foundation upon execution. The required elements of this Agreement will, among other things, conform with the requirements set forth in the State of California DHS Request for Application ("RFA") dated September 1994, as amended.

1.15 Medi-Cal Member - is an individual residing in Los Angeles County who is eligible for Medi-Cal and is enrolled in the Foundation Medi-Cal Plan.

1.16 Monthly DHS Payment - is the revenue received by Foundation each month from DHS, as determined by DHS, for the Health Care Services each Medi-Cal Member is to be provided under the Foundation Medi-Cal Plan.

1.16 Primary Care Physician - is either an internist, pediatrician, or family practitioner who has been selected by or assigned to a Medi-Cal Member for the purpose of coordinating Health Care Services under the Foundation Medi-Cal Plan.

1.17 Primary Hospital - is the hospital selected by a Medi-Cal Member at the time of enrollment where most hospital services will be provided to the Medi-Cal Member

1.18 Molina Member - is a person enrolled in the Foundation Medi-Cal Plan who has been assigned to or selected a Molina Participating Physician as his or her Primary Care Physician in accordance with the procedures set out in Addendum E hereto.

1.19 Molina Participating Facility - is a licensed acute-care facility which is owned by or has contracted with Molina to furnish Health Care Services to Molina Members.

1.20 Molina Participating Physician - is a licensed physician or osteopath or group of physicians or osteopaths which has contracted with or is employed by Molina to provide or arrange Health Care Services to Molina Members.

1.21 Molina Participating Providers - are Participating Physicians, Participating Facilities and other providers, such as ancillary service providers, which contract with Molina to provide Health Care Services to Molina Members.

1.22 Molina Service Area - The geographic area in Los Angeles County in which, as of the Commencement Date of this Agreement, Molina is licensed by the DOC to provide or arrange Health Care Services for its Medi-Cal enrollees. The Molina Service Area is described in Exhibit A, attached hereto and incorporated herein. The Molina Service Area may be revised in Los Angeles County upon the approval of the DOC and DHS.

1.23 Molina Subcontracts - are the contracts entered into between Molina and Molina Participating Providers for the performance of Health Care Services.

1.24 Waxman-Duffy Act - is the Waxman-Duffy Prepaid Health Plan Act (commencing at Section 14200 of the California Welfare and Institutions Code), and the rules and regulations promulgated thereunder by the DHS.

ARTICLE II - MOLINA'S DUTIES

2.01 Arrange Health Care Services - Molina shall provide or arrange all Health Care Services to Molina Medi-Cal Members as identified on the Eligibility List provided by Foundation pursuant to Section 3.04 of this Agreement. Molina's obligation to provide Health Care Services under this Agreement is limited to the Molina Service Area and is subject to Molina's capacity limitation specified in Section 2.04 below.

2.02 Participating Providers.

2.02.01 Standards. All Health Care Services shall be provided by duly licensed, certified or accredited Molina Participating Providers who will provide such services consistent with the scope of their license, certification or accreditation and in accordance with the standards of medical practice in the community. In addition, Molina Participating Providers shall satisfy the standards for participation and all applicable requirements for providers of health services under the Medi-Cal Program as set forth in Title 22 of the California Code of Regulations, Article 4, Section 51200 et seq. Molina agrees that Molina Facilities shall comply with the facility standards established by DHS as set forth in Title 22, California Code of Regulations. Molina shall cooperate with inspections of Molina Participating Providers, as conducted by DHS or Foundation staff, that are required to assure compliance with DHS and Foundation standards.

2.02.02 Adequacy and Availability. Molina shall demonstrate the continuous availability and accessibility of adequate numbers of Molina Participating Providers to provide Health Care Services to Molina Members on a 24-hour basis, seven (7) days a week, including the provision of Emergency Services. Molina will have as a minimum the following:

(i) One full-time equivalent Primary Care Physician per two thousand (2,000) prepaid persons;

(ii) One full-time equivalent physician per one thousand two hundred (1,200) prepaid persons;

(iii) One full-time equivalent non-physician medical practitioner per one thousand (1,000) prepaid persons; and

(iv) One(1) designated Emergency Services facility in Los Angeles County, providing care on a 24-hour basis, seven (7) days a week.

2.02.03 List of Providers. Molina shall provide to Foundation at the time of the execution of this Agreement a complete list of the names, addresses, specialities, license numbers and normal hours of operation for each Molina Participating Physician and the names and addresses of each Molina Participating Provider other than a Molina Participating Physician who will be providing Health Care Services under the Foundation Medi-Cal Plan. Molina agrees to provide Foundation with any additional provider information required by the DHS and DOC.

2.02.04 Changes in Provider Network. Molina will provide Foundation an updated list of Molina Participating Providers on a monthly basis and Foundation shall publish either a new Participating Provider Directory or an amendment to the existing Participating Provider Directory as required by DHS. Molina's updated monthly list shall identify those Molina Participating Providers which have been added or deleted from the previous monthly list of Molina Participating Providers, and those Molina Participating Providers that have changed office locations. Molina shall immediately inform Foundation of the termination of any Molina Primary

Care Physician so that Foundation may reassign all linked Molina Members. When a Molina Participating Provider moves to a new facility, Molina shall conduct an on-site inspection of such new facility as required by law. In addition, Molina shall immediately inform Foundation of any other type of provider change that may impact Foundation's responsibilities under the Medi-Cal Agreement of law. In the event of termination of a Molina Participating Provider for any reason, Molina remains responsible for the continued provision of Health Care Services to all Molina Members, including those who are receiving Health Care Services from the terminated Molina Participating Provider.

2.02.05 Primary Care Physician. Molina shall ensure that an appropriate Primary Care Physician is available for each Molina Member. A Molina Member may select a Primary Care Physician or Foundation may assign a Molina Member to a Primary Care Physician.

2.03 Insurance. Molina shall maintain professional liability insurance and general liability and errors and omissions liability insurance in the minimum amounts of five million dollars ($5,000,000) per person and ten million dollars ($10,000,000) total liability for coverage of Molina, its agents and employees. In the event Molina procures a claims made policy, as distinguished from an occurrence policy, Molina shall procure and maintain prior to termination of such insurance, continuing extended reporting coverage for the maximum term provided in the professional liability policy. Molina shall notify Foundation of any material changes in insurance coverage and shall provide a certificate of such insurance to Foundation upon request. Molina shall require Molina Participating Providers to maintain insurance consistent with the standards of the relevant community.

2.04 Acceptance of Members and Limitation on Enrollment. Molina shall accept as Molina Members all Foundation Medi-Cal Members who chose a Molina Primary Care Physician or who are assigned to Molina in accordance with the procedures, and up to the enrollment limitation, set out in Addendum E hereto.

2.05 Coordination of Benefits. Molina may recover the costs of Health Care Services rendered to a Molina Member to the extent a Molina Member is covered for such services under any other state or federal medical care program or under other contractual or legal entitlement, including, but not limited to, private group or individual indemnification programs, in accordance with applicable coordination of benefits laws.

2.06 Third Party Liability. Neither Molina nor Molina Participating Providers may attempt to recover costs of Health Care Services in circumstances involving casualty insurance, tort liability or workers' compensation. Molina shall notify Foundation within five (5) calendar days of discovering any circumstances involving a Molina Member which may result in the Molina Member recovering tort liability payments, casualty insurance payments or workers' compensation awards. Molina shall also provide to Foundation such other related information as required under the Medi-Cal Agreement (see Section 3.41 of the draft Medi-Cal Agreement). The parties understand and agree that the Medi-Cal Agreement provides that said recoveries are the exclusive property of the DHS.

2.07 Molina Licensure and Compliance.

2.07.01 Knox-Keene License. Throughout the term of this Agreement, Molina shall maintain Knox-Keene licensure in good standing with the DOC.

2.07.02 Regulatory Approval. Molina shall use its best efforts and take all necessary steps to obtain, prior to the date operations commence under this Agreement and throughout the term of this Agreement, via appropriate approval by all applicable regulatory bodies, including, without limitation, the DOC, approval for Molina to participate in the Foundation Medi-Cal Plan and to provide Health Care Services under this Agreement within the Molina Service Area. Molina shall provide to Foundation written evidence of such approval prior to enrolling any Molina Members pursuant to this Agreement.

2.07.03 Approved Molina Service Area. Molina shall enroll persons under this Agreement only within the Molina Service Area for Medi-Cal enrollees.

2.07.04 Licensure Changes/Limitations. Molina shall notify Foundation in writing within five (5) working days in the event of any suspension, restriction or limitation is placed on its licensed Molina Service Area by the DOC.

2.08 Quality Assurance and Remedial Procedures. The parties shall mutually agree upon and implement a quality assurance program for application to Foundation Medi-Cal Members, in accordance with the requirements of the Knox-Keene Act, the Waxman-Duffy Act and the Medi-Cal Agreement. The Foundation Medi-Cal Plan quality assurance program shall include maintenance of a Foundation Medi-Cal Plan Quality Assurance Committee which shall be responsible for oversight of all Health Care Services provided to Foundation Medi-Cal Members. The Foundation Medi-Cal Plan Quality Assurance Committee may be established as a subcommittee of the Foundation Quality Assurance Committee. A Molina designated physician shall participate in the Foundation Medi-Cal Plan Quality Assurance Committee. Molina shall additionally maintain an independent Quality Assurance Committee for reviewing matters related to Molina Members which shall meet at least monthly. Molina may satisfy this requirement by establishing a Subcommittee to the Molina Quality Assurance Committee. Molina shall, through its Medi-Cal Plan Quality Assurance Committee or Subcommittee, perform quality assurance reviews of Health Care Services provided to Molina Members in compliance with the Foundation Medi-Cal Plan quality assurance program as brought before Molina internally or from Foundation's Medi-Cal Plan Quality Assurance Committee, the DOC, DHS and any other governmental agencies with regulatory or enforcement jurisdiction over this Agreement. The Molina Quality Assurance Committee shall keep minutes of the committee meetings, a copy of which shall be made available to the Foundation Medi-Cal Plan Quality Assurance Committee. A Foundation designated physician shall participate in the Molina Quality Assurance Committee's review of Molina Member matters.

Notwithstanding any provision in this Agreement to the contrary, Molina shall, at its sole cost, engage an outside quality management firm satisfactory to Foundation (e.g., MEDSTAT) to

perform facility inspections and medical chart audits of every Molina Participating Provider which is not a Foundation Participating Provider. Such facility inspections and medical chart audits shall be conducted in accordance with Foundation's standards. The facility inspections and medical chart audits shall be completed during the implementation period of the Medi-Cal Agreement and repeated annually thereafter during the term of this Agreement. Molina shall assure that Molina Participating Providers implement any corrective action plan identified as being necessary by the outside quality management firm. On or about August 1, 1996, Foundation will evaluate Molina's capacity to conduct its own facility inspections and medical chart audits in accordance with Foundation's standards. Foundation will at that time strike the requirement that such work be done by a third party if Foundation determines that Molina has developed an internal capacity which meets Foundation standards. If on said date Foundation determines that Molina has not developed said internal capacity, Foundation will strike the requirement on such later date as Foundation determines that Molina has developed said internal capacity.

Molina and Molina Participating Providers shall abide by Foundation's written Quality Management Program, and Foundation's policies and procedures, including: (1) Oversight of Quality Management Functions to Medical Groups and IPAs; (2) Assessment of Medical Groups and IPAs for Delegated Quality Management; (3) Monitoring and Oversight of Quality Management Activities of Network Providers; (4) Delegation of Quality Management - HMO Coalition Studies; (5) Delegation of Quality Management - Medical Records Audits; (6) Delegation of Quality Management - Medi-Cal Facility Inspections; and (7) Standards for Delegated Quality Improvement.

2.09 Utilization Review. Molina shall develop a utilization review program in conformance with the requirements of the DOC, DHS and the Foundation Medi-Cal Plan Quality Assurance Committee. Molina shall maintain a Utilization Review Committee which shall meet as frequently as necessary. The Utilization Review Committee shall keep minutes of the committee meetings, copies of which shall be made available to Foundation. Molina shall review elective referral and hospital admissions on a concurrent and prospective basis and Emergency Services on a retrospective basis.

2.10 Credentialling. Molina shall be responsible for credentialing Molina Participating Providers in accordance with the standards of the DOC and DHS and the Foundation Medi-Cal Plan Quality Assurance Committee.

2.11 Non-discrimination. Molina and Molina Participating Providers shall not unlawfully discriminate against any employee nor applicant for employment because of race, religion, color, national origin, ancestry, physical handicap, medical condition, marital status, age (over 40) or sex. Molina and Molina Participating Providers shall ensure that the evaluation and treatment of their employees and applicants for employment are free of such discrimination. Molina and Molina Participating Providers shall comply with the provisions of the Fair Employment & Housing Act (California Government Code, Section 12990, et seq.) and the applicable regulations promulgated thereunder (CCR, Title 2, Section 7285.0, et seq.). The applicable regulations of the Fair Employment and Housing Commission implementing

Government Code, Section 12990, set forth in Chapter 5 of Division 4 of Title 2 of the CCR are incorporated into this Agreement by reference and made a part hereof as if set forth in full. Molina and Molina Participating Providers shall give written notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreement. Molina shall include the non-discrimination and compliance provisions of this Section in all subcontracts to perform services under this Agreement.

Molina and Molina Participating Providers shall not discriminate against Medi-Cal Members because of race, color, creed, religion, ancestry, marital status, sexual orientation, national origin, age (over 40), sex, or physical or mental handicap in accordance with Title VI of the Civil Rights Act of 1964, 42 USC Section 2000d, rules and regulations promulgated pursuant thereto, or as otherwise provided by law or regulation.

2.12 Accounts Payable System.

2.12.01 Provider Claims. Molina agrees to operate its accounts payable system in a manner which assures that providers of authorized Health Care Services, including Molina Participating Providers and noncontracting providers, receive timely payment for Health Care Services rendered to Molina Members. For purposes of this Agreement, timely payment shall mean payment within the time specified in the applicable agreement between Molina and the provider. If such agreement does not specify a time period or if no agreement is in place, timely payment shall mean payment within the time periods required by California law.

2.12.02 Member Claims. Molina shall pay uncontested claims for Emergency Services or other Health Care Services for which a Molina Member has been billed within thirty (30) working days of receipt of a claim. If the claim is contested by Molina, Molina shall notify the Molina Member that the claim is contested within the time period specified in this paragraph and shall provide Foundation a copy of the notice. The notice shall identify the portion of the claim that is contested and the specific reasons for contesting the claim.

2.13 Protection of Members. Molina may not impose any limitations on the acceptance of Medi-Cal Members for care or treatment that it does not impose on its non-Medi-Cal Members. Neither Foundation, Molina, nor any Molina Participating Provider may request, demand, require or seek directly or indirectly the transfer, discharge, or removal of any Medi-Cal Member for reasons of the Medi-Cal Member's need for, or utilization of, Health Care Services.

2.14 Child Health and Disability Prevention ("CHDP") Program Services. Molina agrees to maintain and operate a system which ensures the provision of CHDP services to Medi-Cal Members under the age of 21 in accordance with Title 17, California Code of Regulations, Section 6800 et seq.

2.15 Identification of Officers, Owners, Stockholders, Creditors. As required by DHS, Molina shall identify the names of the following persons by listing them on Addendum F to this Agreement: (i) Molina officers and owners; (ii) Molina shareholders owning greater than ten

percent (10%) of any stock issued by Molina; and (iii) major creditors holding more than five percent (5%) of any debts owed by Molina. Molina shall notify Foundation within thirty (30) days of any changes in the information provided in Addendum F.

2.16 Molina Subcontracts.

2.16.01 Subcontracts. Molina shall maintain and make available to DHS and Foundation copies of all executed Molina Subcontracts. All Molina Subcontracts shall be in writing and shall be consistent with the terms and provisions of this Agreement and in compliance with applicable State and federal laws. Each Molina Subcontract shall contain the amount of compensation which the Molina Subcontractor will receive under the term of the Molina Subcontract. Each Molina Subcontract shall also provide that the State of California, DHS, Foundation and Molina Members are held harmless in the event Molina does not pay for services under the Molina Subcontract.

2.16.02 Records. Molina shall require all Molina Subcontractors to make their books and records pertaining to Health Care Services available at all reasonable times for inspection, examination, or copying by the DHS, DOC, DOJ, DHHS and Foundation. Molina shall also require all Molina Subcontractors to retain such books and records for a term of at least five years from the close of the fiscal year in which the Molina Subcontract is in effect.

2.16.03 Continuing Care Requirements. Molina shall require all Molina Participating Providers to assist Molina and Foundation in the orderly transfer of the medical care of Molina Members in the event of termination of the Medi-Cal Agreement, including, without limitation, making available to DHS copies of medical records and any other pertinent information necessary for efficient case management of Medi-Cal Members, as determined by DHS.

2.16.04 Continuing Obligations. The obligations of Molina and Molina Subcontractors under this Section 2.16 shall not terminate upon the termination of this Agreement.

2.17 Local Health Department Coordination. As more fully set out in the Medi-Cal Agreement, Foundation will enter inter an agreement for the specified public health services with the Local Health Department ("LHD") in Los Angeles County. The agreement will specify the scope and responsibilities of the County, Foundation, Molina and Universal Care Health Plan, billing and reimbursements, reporting responsibilities, and medical record management to ensure coordinated health care services. The specified public health services under the agreement are as follows:

2.17.01 Family planning services, as specified under the Medi-Cal Agreement.

2.17.02 Sexually transmitted disease ("STD") services diagnosis and treatment of disease episode of the following STDs: syphilis, gonorrehea, chlamydia, herpes simplex, chancroid, trichomoniasis, human papilloma virus, non-gonococcal urethritis, lymphogranuloma venereum

and granuloma inguinale.

2 17.03 Confidential HIV testing, as specified under the Medi-Cal Agreement.

2.17.04 Immunizations, as specified under the Medi-Cal Agreement.

2.17.05 California Children Services.

2.17.06 Maternal and Child Health.

2.17.07 Child Health and Disability Prevention Program.

2.17.08 Tuberculosis Direct Observed Therapy.

2.17.09 Women, Infants, and Children Supplemental Food Program.

2.17.10 Population based Prevention Programs: collaborate in LHD community based prevention programs.

The services specified in Sections 2.17.01 through 2.17.04 require reimbursement to the LHD. The parties understand and agree that Molina shall be responsible for the arrangement, support and coordination of said services, billing and reimbursements, reporting responsibilities, and medical record management to ensure coordinated health care services involving Molina Members.

2.18 Pharmacy and Formulary Compliance. In accordance with Title 22, California Code of Regulations, Section 53214, Molina shall comply with DHS standards for the appropriate use, storage and handling of pharmaceutical items. Molina shall permit periodic audits upon reasonable notice by Foundation or DHS to measure Molina's compliance with DHS standards and to provide recommendations regarding improvement.

2.19 Additional Responsibilities. Molina shall have additional responsibilities as identified in the Matrix of Responsibilities attached hereto and incorporated herein as Addendum G. The specific details for these additional responsibilities shall be mutually agreed upon by the parties and shall be included in a Policies and Procedures Manual that will be jointly developed by the parties.

ARTICLE 3 - DUTIES OF FOUNDATION

3.01 Medi-Cal Agreement. Foundation will endeavor to maintain the Medi-Cal Agreement in effect throughout the term of this Agreement. Foundation will administer the Medi-Cal Agreement and will act as the liaison between DHS and Molina for all purposes related to the provision of Health Care Services to Medi-Cal beneficiaries under the Medi-Cal Agreement.

3.02 Licensure. Throughout the term of this Agreement, Foundation will remain a licensed health care service plan in good standing with the DOC. Foundation shall notify Molina in writing within five (5) working days in the event of any suspension, restriction or limitation placed on its license or approved service area by the DOC.

3.03 Enrollment. Foundation will enroll Medi-Cal Members into the Foundation Medi-Cal Plan in accordance with applicable State and federal laws and the Medi-Cal Agreement. Foundation will assign Medi-Cal Members among Molina, Molina Medical Centers and itself on a rational, fair and alternating basis, as more fully set out in the procedures attached hereto and incorporated herein as Addendum E.

3.04 Verification of Eligibility. Within five (5) days after receipt of the monthly Eligibility List from DHS, Foundation will provide to Molina a copy of such Eligibility List listing the Molina Members based on DHS information. Such Eligibility List for Molina Members shall be provided to Molina in a mutually agreeable electronic data submission format.

3.05 Member Information and Identification Cards. Within seven (7) days after Foundation receives notice of the effective date of enrollment, Foundation shall distribute to new Molina Members (i) the information required to be provided to Molina Members under applicable State laws, including, without limitation, the Foundation Evidence of Coverage, Disclosure Form, and Participating Provider Directory, and (ii) an identification card which identifies the Molina Member as a Foundation Medi-Cal Member.

3.06 Insurance. Foundation shall maintain professional liability insurance and general liability and errors and omissions liability insurance in the minimum amounts of five million dollars ($5,000,000) per person and ten million dollars ($10,000,000) total liability for coverage of Foundation, its agents and employees. In the event Foundation procures a claims made policy, as distinguished from an occurrence policy, Foundation shall procure and maintain prior to termination of such insurance, continuing extended reporting coverage for the maximum term provided in the professional liability policy. Foundation shall notify Molina of any material changes in insurance coverage and shall provide a certificate of such insurance to Foundation upon request.

3.07 Management of Delegated Quality Improvement Activities. As more fully set out in the Medi-Cal Agreement, Foundation will maintain a system to ensure accountability of delegated quality improvement ("QIP") activities including:

3.07.01 Maintenance of policies and procedures which describe delegated activities, QIP authority, function, and responsibilities, how Molina will be informed of the scope of QIP responsibilities, and Molina's accountability for delegated activities.

3.07.02 Establish reporting standards to include findings and actions taken by Molina as a result of QIP activities with the reporting frequency to be at least quarterly.

3 07.03 Maintenance of written procedures and documentation of continuous monitoring and evaluation of the delegated functions, evidence that the actual quality of care being provided meets professionally recognized standards.

3.07.04 Assurance and documentation that Molina has the administrative capacity, task experience, and budgetary resources to fulfill its responsibilities.

3.07.05 Foundation will approve Molina's QIP, including its policies and procedures which meet Foundation's standards.

3.07.06 Foundation will ensure that the actual quality of care being provided is being continuously monitored and evaluated.

3.07.07 Foundation will investigate all potential quality issues involving Molina Members and Molina Participating Providers and shall take appropriate action upon finding an actual quality issue. Molina and its Participating Providers shall cooperate with such investigations and abide by Foundation's determinations.

3.08 Management of Delegated Credentialling Activities. As more fully set out in the Medi-Cal Agreement, Foundation is responsible for the implementation and maintenance of policies and procedures which delineate the credentialing activities which are delegated to Molina under this Agreement, and Foundation shall monitor such activities. The parties understand and agree that Molina shall ensure the qualification of all Molina Participating Providers, approve new providers and sites, and terminate or suspend individual providers, in accordance with the standards of the DOC and DHS and the Foundation Medi-Cal Plan Quality Assurance Committee. Foundation shall perform on-site inspections and investigations of Molina Participating Providers as required by the DHS and as necessary to investigate a potential quality issue involving a Participating Provider, and Molina and Molina Participating Providers shall cooperate with Foundation's inspections and investigations.

3.09 Management of Delegated Utilization Review Activities. As more fully set out in the Medi-Cal Agreement, Foundation is responsible for the implementation and maintenance of a utilization management program which meets the requirements of the Medi-Cal Agreement. The parties understand and agree that Molina shall develop a utilization review program in conformance with the requirements of the Medi-Cal Agreement, DOC, DHS and the Foundation Medi-Cal Plan Quality Assurance Committee. Molina shall maintain a Utilization Review Committee which shall meet as frequently as necessary. The Utilization Review Committee shall keep minutes of the committee meetings, copies of which shall be made available to Foundation. Molina shall review elective referral and hospital admissions on a concurrent and prospective basis and Emergency Services on a retrospective basis. Foundation shall ensure that said delegated utilization management activities are regularly evaluated and approved and that the such process is documented.

3.10 Member Satisfaction Surveys. Foundation will conduct member satisfaction

surveys of Molina Members as required under the Medi-Cal Agreement.

3.11 Additional Responsibilities. Foundation shall have additional responsibilities as identified in the Matrix of Responsibilities attached hereto and incorporated herein as Addendum G. The specific details for these additional responsibilities shall be mutually agreed upon by the parties and shall be included in a Policies and Procedures Manual that will be jointly developed by the parties.

ARTICLE 4 - JOINT RESPONSIBILITIES

4.01 Solicitation of Enrollment. The parties shall mutually develop a plan for marketing the Foundation Medi-Cal Plan and Molina's participation in the Foundation Medi-Cal Plan. The marketing plan shall be developed in compliance with all applicable laws.

4.02 Agency Inquiries and Complaints. Any party receiving any inquiry, complaint, deficiency notice or request for corrective action from DHS, DOC, DOJ or the DHHS relating to Molina's arrangement of Health Care Services under this Agreement, or relating to the administration of the Foundation Medi-Cal Plan or to the arrangement of Health Care Services to Medi-Cal Members, shall notify the other party within one (1) working day of the receipt of the matter. The parties shall cooperate fully and as necessary to resolve such matters.

4.03 Member Grievance Procedures. Molina shall abide by Foundation's Member Grievance Procedures which are attached hereto and incorporated herein as Addendum H. Molina shall abide by, and implement upon request, all Foundation, DOC and DHS determinations on Molina Member appeals and grievances. Molina understands and further agrees as follows.

4.03.01 Foundation will publish a single form of Evidence of Coverage for its Los Angeles County Medi-Cal Members. The Evidence of Coverage and Foundation's separately stated written Member grievance procedures attached hereto as Addendum H will contain a single Foundation telephone number and single Foundation address for receipt of Medi-Cal Member customer service inquiries, appeals and grievances. If Molina receives a written grievance or appeal involving a Molina Member, it will fax same to Foundation's Director of Medi-Cal Customer Service within one (1) working day of receipt.

4.03.02 Foundation will mail all letters acknowledging receipt of a grievance or appeal to Molina Members. Foundation will forward first level Molina Member appeals and grievances to Molina for initial review. However, for grievances which Foundation determines to involve a potential quality issue and Molina or a Molina Participating Provider, Foundation shall also conduct a concurrent review of such grievances.

4.03.03 For Molina Member grievances involving a potential quality issue, Molina shall, within 15 calendar days of the receipt of the grievance, submit all applicable records and its written findings, recommendations and proposed corrective action plan where applicable, to

Foundation's Director of Medi-Cal Customer Service for Foundation's review and determination on the matter. Molina and Molina Participating Providers shall cooperate fully in Foundation's handling of such grievances.

4.03.04 If Molina's review determination on a Molina Member's first level appeal or grievance not involving a potential quality issue is to overturn its previous denial of coverage or to remedy the grievance to the Molina Member's satisfaction, then Molina will draft an appropriate letter in a form approved by Foundation and on Foundation's letterhead and mail the letter to the Molina Member. Molina shall also provide a copy of the response to Foundation.

4.03.05 If Molina's review recommendation on a Molina Member's first level appeal or grievance not involving a potential quality issue is to uphold its previous denial of coverage or to not remedy the grievance to the Molina Member's satisfaction, then Molina will, within 15 calendar days of the receipt of the appeal or grievance, draft an appropriate written response in a form approved by Foundation and fax same with all supporting medical records and other documentation to Foundation's Director of Medi-Cal Customer Service for Foundation's review and determination on the matter. Foundation will, in its sole discretion, reasonably determine to (i) ratify Molina's review recommendation; (ii) modify Molina's review recommendation; or (iii) reject Molina's review recommendation and direct Molina to arrange and cover the disputed service or to remedy the grievance to the reasonable satisfaction of the Molina Member. In the event that Foundation determines to ratify Molina's review recommendation, Foundation will so advise Molina and Molina will mail the letter to the Molina Member. In the event that Foundation determines to modify Molina's review recommendation, Foundation will so advise Molina and Foundation will draft the response, mail the letter to the Molina Member, and provide a copy to Molina. In the event that Foundation determines to reject Molina's review recommendation, Foundation will so advise Molina and Foundation will draft the response, mail the letter to the Molina Member, and provide a copy to Molina.

4.03.06 Foundation will handle all second level Molina Member grievance hearings and DHS reviews. Molina shall cooperate fully and provide assistance as requested by Foundation, and shall appear and participate at the hearings if requested by Foundation.

4.03.07 Molina shall abide by, and implement upon request, all Foundation, DOC and DHS determinations on Molina Member appeals and grievances. If Molina fails to implement a determination of Foundation, DOC or DHS in a timely manner, Foundation may arrange and cover the disputed service or remedy the grievance to the reasonable satisfaction of the Molina Member and offset the cost of same from Foundation's payment under this Agreement to Molina.

4.03.08 Molina will maintain a written log of all appeals, grievances and DOC and DHS complaints involving Molina Members and provide a copy of same to Foundation on a monthly basis.

4.04 Reciprocity. If and only to the extent current contracts permit reciprocity, Foundation shall make good faith efforts to provide reciprocity at Foundation rates on claims for

Health Care Services provided to Molina Members by providers who contract with Foundation but who are not Molina Participating Providers. Likewise, if and only to the extent current contracts permit reciprocity, Molina shall make good faith efforts to provide reciprocity at Molina rates on claims for Health Care Services provided by Molina Participating Providers to Medi-Cal Members assigned to Foundation.

4.05 Requests for Transfers. The parties shall cooperate in arranging Member transfers in the event a Molina Member requests a non-Molina Primary Care Physician but desires to remain a Foundation Medi-Cal Member or in the event a Foundation Medi-Cal Member requests a transfer in order to select a Molina Primary Care Physician.

4.06 Additional Responsibilities. The parties shall have additional responsibilities as identified in the Matrix of Responsibilities attached hereto and incorporated herein as Addendum G. The specific details for these additional responsibilities shall be mutually agreed upon by the parties and shall be included in a Policies and Procedures Manual that will be jointly developed by the parties.

ARTICLE 5 - COMPENSATION

Foundation shall pay Molina Capitation Payments at the rates and according to the procedures set forth in Addendum I attached hereto and incorporated herein.

ARTICLE 6 - TERM

The initial term of this Agreement shall commence concurrently with the effective date of the Medi-Cal Agreement (the "Commencement Date") and shall continue for the full term of the Medi-Cal Agreement and any extensions thereto, unless sooner terminated as set forth in Article 7 below.

ARTICLE 7 - TERMINATION

7.01 Molina's Right to Termination. Subject to the prior written approval of DHS, Molina shall have the right to terminate this Agreement immediately upon written notice to Foundation in the following circumstances:

(i) revocation, suspension or expiration of Foundation's license as a health care service plan pursuant to the Knox-Keene Act;

(ii) Foundation's breach of any material term, covenant or condition of this Agreement and subsequent failure to cure such breach within thirty (30) calendar days after notice by Molina of such breach. The remedy of such breach within thirty (30) calendar days of receipt of such notice shall revive this Agreement for the remaining term, subject to any of the rights of termination contained in this or any other provision of this Agreement; or

(iii) Foundation's material failure to comply with the Medi-Cal Agreement, the

Knox-Keene Act or the Waxman-Duffy Act or the rules and regulations promulgated thereunder, as evidenced by a deficiency notice or cease and desist letter from DOC or DHS, and failure to cure such material failure within forty-five (45) days of the receipt of such notice from DOC or DHS.

7.02 Foundation's Right to Termination. Subject to the prior written approval of DHS, Foundation shall have the right to terminate this Agreement immediately upon written notice to Molina in the following circumstances:

(i) revocation, suspension or expiration of Molina's license as a health care service plan pursuant to the Knox-Keene Act;

(ii) Molina's breach of any material term, covenant or condition of this Agreement and subsequent failure to cure such breach within thirty (30) calendar days after notice by Foundation of such breach. The remedy of such breach within thirty (30) calendar days of receipt of such notice shall revive this Agreement for the remaining term, subject to any of the rights of termination contained in this or any other provision of this Agreement; or

(iii) Molina's material failure to comply with the Medi-Cal Agreement, the Knox-Keene Act or the Waxman-Duffy Act or the rules and regulations promulgated thereunder, as evidenced by a deficiency notice or cease and desist letter from DOC or DHS, and failure to cure such material failure within forty-five (45) days of the receipt of such notice from DOC or DHS.

7.03 Termination of Medi-Cal Agreement. This Agreement shall immediately terminate upon the termination or nonrenewal of the Medi-Cal Agreement. Such termination of obligations shall be accomplished by delivery of written notice to Molina of the date upon which such termination shall become effective.

7.04 Termination Without Cause. Subject to the prior written approval of DHS, either party may terminate this Agreement with or without cause effective upon the renewal date of the Medi-Cal Agreement by giving written notice to the other party at least one hundred eighty (180) days prior to renewal of the Medi-Cal Agreement.

7.05 Notification of DHS of Amendment or Termination. Molina shall notify DHS in the event of an amendment or termination of this Agreement. Notice shall be given by properly addressed letter deposited in the United States Postal Service as first-class postage-prepaid registered mail. Any termination under Sections 7.01, 7.02 or 7.04 above is subject to the prior written approval of DHS.

7.06 Termination of Enrollment of a Molina Member. Termination of enrollment of a Molina Member shall be in accordance with the terms of the Foundation Medi-Cal Plan and shall be upon the mutual agreement of the parties.

7.07 Continuing Care Period. Molina shall continue to provide Health Care Services to

Molina Members as required by this Agreement after the effective date of termination of this Agreement until either (i) such services are complete or the Molina Member can be safely transferred to the care of another provider and such transfer does not violate State laws regarding abandonment of patients, or (ii) Foundation has made provisions for the assumption of such services, whichever occurs first. Foundation will use its best efforts to provide for the assumption of such services as soon as is reasonably practicable, taking into account the best interests of the Molina Member and the availability of appropriate providers. Compensation to Molina during this continuing care period will be compensated at the DHS Medi-Cal fee schedule.

ARTICLE 8 - DISPUTE RESOLUTION

8.01 Arbitration. The parties agree to meet and confer in good faith to resolve any problems or disputes that may arise under this Agreement. Such negotiation shall be a condition precedent to the filing of any arbitration demand by either party. Any controversy, dispute or claim between the parties arising out of or relating to interpretation, performance or breach of this Agreement shall be resolved by binding arbitration at the request of either party, in accordance with the California Arbitration Act, California Code of Civil Procedure, Sections 1280-1294.2. The arbitration shall be conducted in Los Angeles, California by a single, neutral arbitrator who is licensed to practice law in the State of California. The arbitration shall be conducted under the auspices of Judicial Arbitration & Mediation Services, Inc. ("JAMS"), except that if JAMS is nor longer in existence or is otherwise unable to appoint a neutral arbitrator, the parties shall conduct arbitration in accordance with the Commercial Rules of the American Arbitration Association ("AAA") as supplemented by the provisions in this Section 8.01. If the parties are unable to agree on the choice of the arbitrator, then the parties agree that either JAMS or AAA shall appoint a neutral arbitrator.

The arbitrator shall apply California substantive law and federal substantive law where State law is preempted. Civil discovery for use in such arbitration may be conducted in accordance with the California Code of Civil Procedure and the California Evidence Code, and the arbitrator selected shall have the power to enforce the rights, remedies, duties, liabilities, and obligations of discovery by the imposition of the same terms, conditions and penalties as can be imposed in like circumstances in a civil action by a superior court of the State of California. The provisions of California Code of Civil Procedure Section 1283 and 1283.05 concerning the right to discovery and the use of depositions in arbitration are incorporated herein by reference and made applicable to this Agreement. Each party shall have the right to take no more than three (3) depositions of individuals or entities, including depositions of expert witnesses, and copies of all exhibits and demonstrative evidence to be used at the arbitration. However, rebuttal and impeachment evidence need not be exchanged until presented at the arbitration hearing.

The arbitrator shall have the power to grant all legal and equitable remedies and award compensatory damages provided by California law, except that punitive damages may not be awarded. The arbitrator shall prepare in writing and provide to the parties an award including factual findings and the legal reasons on which the decision is based. The arbitrator shall not have the power to commit errors of law or legal reasoning, and the award may be vacated or corrected

pursuant to California Code of Civil Procedure Sections 1286.2 or 1286.6 for any such error.

Notwithstanding the above, in the event either party wishes to obtain injunctive relief or a temporary restraining order, such party may initiate an action for such relief in a court of law and the decision of the court of law with respect to the injunctive relief or temporary restraining order shall be subject to appeal only through the courts of law. The courts of law shall not have the authority to review or grant any request or demand for damages or declaratory relief.

ARTICLE 9 - RECORDS AND DATA COLLECTION

9.01 Maintenance of Records. Molina shall maintain and provide to the DHS, DOC, DOJ, DHHS and Foundation all books, records, patient records, encounter data (in a format approved by Foundation), and other information as may be necessary for compliance by the parties with the Knox-Keene Act, the Waxman-Duffy Act, and all other applicable law. Such books and records shall be maintained in a form in accordance with the general standards and laws applicable to such book or record keeping, including medical histories, records and reports from other providers, hospital discharge summaries, records of Emergency Services and such other information as said parties may require or as necessary to disclose the quality, appropriateness or timeliness of Health Care Services provided to Molina Members under this Agreement. The obligations under this Section shall not terminate upon the termination of this Agreement, whether by rescission or otherwise.

The parties shall keep and maintain their books and records on a current basis in accordance with general standards for book and record keeping. The parties shall retain said records for a term of at least five years from the close of the fiscal year in which this Agreement is in effect.

9.02 Right to Inspect. Molina shall make available for inspection, examination or copying by the DHS, DOC, DOJ, DHHS and Foundation at reasonable times at Molina's usual place of business, or at such other mutually agreeable place in California, all books, records, patient records, encounter data, and other information relating to the services provided pursuant to this Agreement, including, but not limited to, Molina Member patient records, subject to the confidentiality restrictions set forth in Section 9.03, and financial records pertaining to the cost of operations and income received for Health Care Services provided to Molina Members. The right of said parties to inspect, evaluate and audit such records shall extend through five (5) years from the date of termination of this Agreement.

9.03 Confidentiality. The parties shall maintain the confidentiality of Molina Member medical records and related information in accordance with applicable federal, State and local laws, including, without limitation, Title 45, Section 250.50 of the Code of Federal Regulations, and Welfare and Institutions Code Section 1400.2 and the regulations promulgated thereunder. Where required by law, the parties shall obtain a specific written authorization from the Molina Member prior to releasing the Molina Member's medical records. The parties shall establish and maintain procedures and safeguards so that no information pertaining to Medi-Cal Members contained in the parties' records or obtained from DHS in carrying out the terms of this

Agreement shall be used or disclosed by the parties or their agents or employees other than for purposes directly connected with the administration of the Foundation Medi-Cal Plan.

9.04 Financial Statements. Molina shall provide to Foundation copies of the quarterly financial reports submitted by Molina to the DOC. Foundation shall provide to Molina copies of the quarterly financial reports submitted by Foundation to the DOC

9.05 Provision of Data. The parties shall jointly and separately maintain statistical records and data relating to the utilization of Health Care Services by Molina Members as required for the administration of the Foundation Medi-Cal Plan and in compliance with all DHS and DOC statistical, financial and encounter data reporting requirements. Encounter data shall be submitted in a format approved by Foundation and on a timely basis so that Foundation can meet its regulatory reporting requirements.

ARTICLE 10 - RELATIONSHIP OF PARTIES

10.01 Independent Contract Relationship. The relationship between the parties is one of independent contractors. Nothing in this Agreement is intended to create nor will be deemed or construed to create any relationship between the parties other than that of independent contracts. Neither of the parties, nor any of their respective officers, directors or employees, shall act as nor be construed to be the partner, agent, employee or representative of the other. The relationship between the parties, as a subcontractor of Foundation, and DHS and the State of California are independent contractor relationships. Neither Foundation nor Molina nor any agents, officers or employees of Foundation or Molina are agents, officers, employees, partners or associates of DHS or the State of California. None of the provisions of this Agreement shall be construed to create a relationship of partnership, agency, joint venture or employment between Foundation or Molina, as a subcontractor of Foundation, and DHS and the State of California.

10.02 Indemnification. The parties will indemnify and hold each other harmless against any claims, demands, damages, liability, judgments and expenses, including reasonable attorney fees, as follows:

10.02.01 To the extent that any allegations against Molina are based on alleged fault by Molina (or its agents, employees or providers) in providing or failing to provide Health Care Services to Molina Members or in other administrative dealings with Molina Members, and the allegations against Foundation are based on vicarious, passive or secondary liability, including, without limitation, allegations of apparent or ostensible agency and negligent selection, Molina will fully indemnify Foundation against such claims, including attorney fees and costs.

10.02.02 To the extent that any allegations against Foundation are based on alleged fault by Foundation (or its agents, employees or providers) in providing or failing to provide Health Care Services to Molina Members or otherwise failing to perform under the Medi-Cal Agreement or under the Foundation Medi-Cal Plan, and the allegations against Molina are based on vicarious, passive or secondary liability, including, without limitation, allegations of

apparent or ostensible agency and negligent selection, Foundation will fully indemnify Foundation against such claims, including attorney fees and costs.

10.02.03 To the extent of any other claims, the parties will mutually indemnify each other, including attorney fees and costs, in proportion to the relative degree of each party's fault that contributed to the claim. In interpreting this paragraph, the principals of comparative fault shall apply.

10.03 Cooperation. The parties shall maintain an effective liaison and close cooperation with one another to ensure smooth working relationships with Medi-Cal Members, effective communication between providers, and maximum benefits to each Medi-Cal Member at the most reasonable cost, consistent with quality of Health Care Services.

ARTICLE 11 - MISCELLANEOUS

11.01 Assignment. This Agreement and the rights, interests, and benefits hereunder shall not be assigned, transferred, pledged, or hypothecated in any way by the parties and shall not be subject to execution, attachment or similar process nor shall the duties imposed herein be subcontracted or delegated without the written consent of the other party. Any assignment or delegation of the Agreement shall be void unless prior written approval is obtained from the DHS.

11.02 Amendments. The parties may amend this Agreement by providing thirty (30) days' prior written notice to the other party in order to maintain compliance with applicable federal and State laws. Such amendment shall be binding upon the parties. Other amendments to this Agreement shall be effective only upon mutual written consent.

11.03 Confidentiality of this Agreement. To the extent possible, each party agrees to maintain the terms of this Agreement confidential. Disclosure of the terms of this Agreement, other than disclosures required by the DOC or DHS, shall not be made without the approval of the other party.

11.04 Notices. All notices required or permitted by this Agreement shall be in writing and may be delivered in person or may be sent by regular, registered or certified mail or United States Postal Service Express Mail, with postage prepaid, or by facsimile transmission, and shall be deemed sufficiently given if served in the manner specified in this Section 11.04. The addresses below shall be the particular party's address for delivery or mailing of notice purposes:

To Molina: Molina Medical Centers
One Golden Shore
Long Beach, California 90802

ATTENTION: C. David Molina, M.D.

To Foundation: Foundation Health, a California Health Plan
3400 Data Drive
Rancho Cordova, California 95670

ATTENTION: President

The parties may change the names and addresses noted above through written notice in compliance with this Section 11.04. Any notice sent by registered or certified mail, return receipt requested, shall be deemed given on the date of delivery shown on the receipt card, or if not delivery date is shown, the postmark date. If sent by regular mail, the notice shall be deemed given forty-eight (48) hours after the notice is addressed and mailed with postage prepaid: Notices delivered by United States Express Mail or overnight courier that guarantee next day delivery shall be deemed given twenty-four (24) hours after delivery of the notice to the United States Postal Service or other courier. If any notice is transmitted by facsimile transmission or similar means, the notice shall be deemed served or delivered upon telephone confirmation of receipt of the transmission, provided a copy is also delivered via delivery or mail.

11.05 Entire Agreement. This Agreement contains all the terms and conditions between Molina and Foundation concerning the subject matter of this Agreement and supersedes all other agreements, oral or otherwise, including, without limitation, that certain Health Services Agreement entered into by the parties on April 13, 1995.

11.06 Provisions Separable. The invalidity or uneforceability of any term or provision of this Agreement will in no way affect the validity or enforceability of any other term or provision.

11.07 Headings. The headings of the various sections of this Agreement are inserted merely for the purpose of convenience and do not expressly, or by implication, limit or define or extend the specific terms of the section so designated.

11.08 Waiver of Breach. The waiver by either party of a breach or violation of any provision of this Agreement shall not operate as or be construed to be a waiver of any subsequent breach thereof.

11.09 Applicable Law and Compliance with Medi-Cal Agreement. This Agreement shall be governed in all respects by the laws of the State of California and applicable federal law, including, without limitation, (i) the Knox-Keene Act and the regulations promulgated thereunder by the DOC; and (ii) the Waxman-Duffy Act and the regulations promulgated thereunder by DHS. Molina shall comply with the terms and conditions of the Medi-Cal Agreement as it relates to the arrangement of Health Care Services to Molina Members and shall cooperate fully with Foundation to assist Foundation to remain in compliance with the Medi-Cal Agreement. Any provision that any law, regulation or the Medi-Cal Agreement requires to be in this Agreement shall bind the parties whether or not specifically provided herein.

11.10 Exhibits. The addenda attached to this Agreement are an integral part of this

Agreement and are incorporated herein by reference.

11.11 Attorney Fees and Costs. If any action at law or suit in equity or arbitration is brought to enforce or interpret the provisions of this Agreement or to collect any monies due hereunder, the prevailing party shall be entitled to reasonable attorney fees and reasonable costs, together with interest at ten percent (10%) per annum, in addition to any and all other relief to which it may otherwise be entitled.

IN WITNESS WHEREOF, the parties have executed this Agreement on the date set forth below.

MOLINA MEDICAL CENTERS	FOUNDATION HEALTH, A CALIFORNIA HEALTH PLAN
By: /s/ John C. Molina	By: /s/
Title: VICE-PRESIDENT	Title: President
Date: FEBRUARY 2, 1996	Date: February 6, 1996

SCHEDULE OF ADDENDA

ADDENDUM A	MOLINA SERVICE AREA
ADDENDUM B	EVIDENCE OF COVERAGE
ADDENDUM C	DISCLOSURE FORM
ADDENDUM D	PARTICIPATING PROVIDER DIRECTORY FOR LOS ANGELES COUNTY
ADDENDUM E	PROCEDURE FOR ASSIGNMENT OF FOUNDATION'S LOS ANGELES COUNTY MAINSTREAM MEDI-CAL MEMBERS AMONG FOUNDATION, MOLINA AND UNIVERSAL CARE HEALTH PLAN
ADDENDUM F	OFFICERS, OWNERS, STOCKHOLDERS, CREDITORS
ADDENDUM G	MATRIX OF RESPONSIBILITIES
ADDENDUM H	FOUNDATION'S MEDI-CAL MEMBER GRIEVANCE PROCEDURES
ADDENDUM I	COMPENSATION

ADDENDUM A

MOLINA SERVICE AREA

(The entirety of Los Angeles County, inclusive of all ZIP Codes)

ADDENDUM B

EVIDENCE OF COVERAGE

(To be developed by Foundation and attached)

ADDENDUM C

DISCLOSURE FORM

(To be developed by Foundation and attached)

ADDENDUM D

PARTICIPATING PROVIDER DIRECTORY FOR LOS ANGELES COUNTY

(To be developed by Foundation and attached)

ADDENDUM E

PROCEDURE FOR ASSIGNMENT OF FOUNDATION'S LOS ANGELES COUNTY MAINSTREAM MEDI-CAL MEMBERS AMONG FOUNDATION, MOLINA AND UNIVERSAL CARE HEALTH PLAN

OVERVIEW OF ENROLLMENT OPTIONS AND PROCESS

Following an enrollment presentation and notification by mail, Los Angeles County Medi-Cal beneficiaries will have thirty days to select either the local initiative plan or Foundation as the mainstream plan. If the beneficiary does not select either plan within the required thirty days, the enrollment contractor will assign the beneficiary to one of the plans. All assignments will be made to the local initiative plan until its total enrollment has reached the minimum enrollment levels for the County. Once this minimum enrollment level has been met, assignments will alternate between the mainstream plan and local initiative plan, taking into account such items as plan capacity and location of service sites in relation to the beneficiary's residence.

ASSIGNMENT OF FOUNDATION'S LOS ANGELES COUNTY MAINSTREAM MEDI-CAL MEMBERS

Prepaid Health Plan Enrollees. If a Medi-Cal beneficiary was a Medi-Cal prepaid health plan enrollee of Foundation, Molina or Universal immediately prior to the commencement date of operations for the Two Plan Model in Los Angeles County, Foundation will assign the Medi-Cal beneficiary to such plan, unless prohibited by the DHS or otherwise requested by the Medi-Cal beneficiary.

Assignment of a Medi-Cal Member Who Selects a PCP Unique to One of the Three Plans. Los Angeles County Medi-Cal beneficiaries who select or who are assigned by the enrollment contractor to Foundation's mainstream plan will be offered the opportunity to select their Primary Care Physician from a single listing of Foundation, Molina and Universal Care Health Plan Primary Care Physicians. If the Medi-Cal Member selects or is assigned to a Primary Care Physician that contracts with only one of the three plans, such health plan will be responsible for the arrangement of Health Care Services for the Medi-Cal Member, but the Medi-Cal Member remains a Medi-Cal Member of Foundation.

Assignment of a Medi-Cal Member Who Either Selects a PCP of Two or Three of the Plans or Who Does Not Select a PCP. If a Medi-Cal Member selects a Primary Care Physician that contracts with two or three of the plans, or the Medi-Cal Member does not select a Primary Care Physician at the time of enrollment, the Medi-Cal Member will be assigned by Foundation to one of the plans on a rational, fair and alternating basis. In making this assignment, Foundation will consider the ability of the plans' available Primary Care Physicians to accommodate the geographic and linguistic needs of the Medi-Cal Member. Where the geographic and linguistic needs of the Medi-Cal Member can be adequately served by Primary Care Physicians of two or more of the plans, Foundation will assign the Medi-Cal Member to the plan which is next due for an assignment on an alternating basis among the three plans.

If a Medi-Cal Member selects a Primary Care Physician that contracts with Molina and Universal, the Medi-Cal Member will be assigned by Foundation to Molina or Universal on a rational, fair and alternating basis.

This forementioned assignment procedure will also apply to Medi-Cal Members who request a Primary Care Physician change but who do not indicate the name of a new Primary Care Physician.

Additionally, if a Medi-Cal Member selects a PCP that contracts with two or three of the plans but requests in writing to be assigned to one of such plans, Foundation will assign the Medi-Cal Member to the requested plan. However, the parties understand and agree that such assignments to Molina and Universal shall only be made until Molina and Universal reach the 26% enrollment limitation described in this Addendum below.

Enrollment Limitation for Molina and Universal. This assignment process will continue until Molina and Universal each achieve a total Medi-Cal membership in Los Angeles County of 26% of the total number of Foundation Medi-Cal Members in Los Angeles County (Foundation will calculate enrollment numbers on a monthly basis). When Molina or Universal achieve such enrollment, these plans will only receive new Medi-Cal Members if they are the sole plan that contracts with the Primary Care Physician selected by the Medi-Cal Member.

If any of the plans is unable to service additional Medi-Cal Members due to lack of capacity, Foundation will assign additional Medi-Cal Members to the remaining plans with capacity using the above procedure.

ADDENDUM F

OFFICERS, OWNERS, STOCKHOLDERS, CREDITORS

Name and address of each person with an ownership or control interest:

NAME	ADDRESS	PERCENT OF OWNERSHIP
Molina Family Trust	One Golden Shore Long Beach, California 90802	100%

OFFICERS:

NAME	TITLE
C. David Molina, M.D., M.P.H.	President & Treasurer
John C. Molina	Secretary & Vice President
Joseph M. Molina, M.D.	Vice President for Medical Operations
Richard Anderson, M.D.	Medical Director
C. Joseph Heinz	Chief Administrative Officer
Harvey Fein	Chief Financial Officer
Mary Martha Molina, M.D.	Vice President, Medical Staff Services

MAJOR CREDITORS

CREDITOR	DESCRIPTION

ADDENDUM G

MATRIX OF RESPONSIBILITIES
(i.e., Division of Responsibilities Between Foundation and Molina)

FUNCTION	EXCLUSIVELY FOUNDATION	EXCLUSIVELY MOLINA	JOINT: EQUAL	JOINT: PRINCIPALLY FOUNDATION	JOINT: PRINCIPALLY MOLINA
MARKETING					
Advertising			X		
Material			X		
Staff			X		
NETWORK DEVELOPMENT					
Provider Contracting		X			
Rate Determination		X			
IPA Management		X			
Office Training & Orientation		X			
Provider Manuals & Bulletins			X		
UTILIZATION REVIEW					
Hospital & Utilization Tracking		X			
Case Management		X			
Specialty Referral Review		X			
Computer Input		X			
Physician/Enrollee		X			
Notification Coordination		X			
On-Call Scheduling		X			
Phone Advice Availability		X			
Coordination of Community Resources		X			
Claims Review		X			
Oversight for Compliance with F's Standards	X				
MEMBERSHIP SERVICES					
Membership Staff				X	
Phone Access	X				
1st Level Grievance Resolution				X	
2nd Level Grievance Resolution (Hearing)	X				
Member Newsletter	X				
Data Collection			X		
Member Rights			X		
Electronic Interface			X		
Cultural & Linguistic				X	
Member Satisfaction Survey	X				
CLAIMS ADJUDICATION					
Claims Review		X			

FUNCTION	EXCLUSIVELY FOUNDATION	EXCLUSIVELY MOLINA	JOINT: EQUAL	JOINT: PRINCIPALLY FOUNDATION	JOINT: PRINCIPALLY MOLINA
Denials		X			
Third Party Liability			X		
Coordination of Benefits		X			
Claims Check Processing		X			
Claims Inventory Monitoring		X			
LAG Study Tracking		X			
IBNR Calculations		X			
Stop-Loss Billing		X			
MANAGEMENT INFORMATION SYSTEMS					
Hardware			X		
Software			X		
Communication			X		
Computer Operations			X		
ENROLLMENT AND ELIGIBILITY					
Enrollment Forms	X				
Evidence of Coverage	X				
Disclosure Form	X				
Welcome Letter	X				
Identification Cards	X				
Enrollment Mailing	X				
Participating Provider Directory (quarterly)	X				
Processing	X				
Enrollment Data Entry	X				
Eligibility List	X				
Electronic Tape Processing			X		
Eligibility Reconciliation	X				
CAPITATION PROCESSING					
Medical Group/IPA Monitoring		X			
Medical Group/IPA Payments		X			
Risk Reserve Calculation		X			
DATA COLLECTION					
Medical Group/IPA Report Cards					X
Physician Profiling					X
HEDIS Reporting			X		
Regulatory Requirements			X		
UNDERWRITING					
Fraudulent Enrollment Resolutions	X				
Governmental Relations Reporting	X				

FUNCTION	EXCLUSIVELY FOUNDATION	EXCLUSIVELY MOLINA	JOINT: EQUAL	JOINT: PRINCIPALLY FOUNDATION	JOINT: PRINCIPALLY MOLINA
QUALITY MANAGEMENT					
Credentialing/Re-credentialing					X
Quality Improvement Operations				X	
Meeting Minutes and Follow-up					X
Chart Review		X			
Standards Development	X				
Network Auditing			X		
Review of Bad Outcome QA Cases			X		
Administration of Disciplinary Action					X
Peer Review					X
Health Education			X		
Policy & Procedure Maintenance			X		
Interface with Public Health			X		
11 Quality of Care Studies				X	
Oversight for Compliance with F's Standards	X				
Review of Potential Quality Issue Grievances				X	
ACCOUNTING					
Accounts Payable			X		
Purchasing			X		
Cash Management			X		
Checking Account Reconciliation			X		
Fee-for-Service Billing		X			
Financial Statements Development			X		
Audits			X		
Insurance Maintenance			X		
Payroll			X		
Budget Development			X		
Budget Monitoring			X		
Purchase of Forms			X		
PHARMACY MANAGEMENT					
Claims Adjudication		X			
Pharmacy Contracting		X			
Mail Order Prescription		X			
Pharmacy Data		X			
Claims Payment		X			
DUR/DUE		X			
OTHER					
Policy and Procedure Manual			X		
Legal			X		
DOC Interface	X				
DHS Interface	X				
Coordination with County Health Department					X

ADDENDUM H

FOUNDATION'S MEDI-CAL MEMBER GRIEVANCE PROCEDURES

I GRIEVANCE PROCESSING

Medi-Cal Members may contact the Member Services Department by telephone (800) 675-6110, in person or in writing to file a grievance.

Foundation will send written acknowledgment to the Medi-Cal Member within five days after receipt of the grievance. The acknowledgment letter will include the time frame and steps that will be taken to resolve the grievance and the Medi-Cal Member's right to request a fair hearing from the Department of Health Services at any time during the process. Grievances will be responded to within 30 days, unless the Medi-Cal Member is notified that additional time is required.

Medi-Cal Members will be notified in writing of Foundation's determination on their grievance. If Foundation's determination is to uphold the initial denial of coverage, the response will include the Medi-Cal Member's right to request a fair hearing from the Department of Health Services, and/or request disenrollment from Foundation should the Medi-Cal Member feel that no satisfactory resolution is possible.

II. FOUNDATION'S INTERNAL APPEAL PROCESS

A. If the Medi-Cal Member is dissatisfied with Foundation's initial determination regarding a claim or request for prior authorization, the Medi-Cal Member may appeal in writing to Foundation at the following address:

Foundation Health, a California Health Plan
Member Services Department, Appeals Unit
333 South Arroyo Parkway
Pasadena, California 91105

If requested, the Member Services Department staff will assist the Medi-Cal Member in writing the appeal. Written appeals must be signed by the Medi-Cal Member (unless incapacitated or a minor), and include any additional information that the Medi-Cal Member wishes Foundation to consider.

The written appeal must be received by Foundation within 30 days of the final action taken on a grievance. Written acknowledgment will be sent to the Medi-Cal Member, within five days of receipt of the written appeal.

Depending on the subject matter of the appeal, the matter may be reviewed by one of Foundation's Medical Directors who has not previously been involved in the grievance, a

member of Foundation's administrative staff, or a provider consultant.

Foundation will notify the Medi-Cal Member in writing of the results of its review and the specific basis of its decision in 30 days following its receipt of the grievance. If additional time is required to resolve the grievance, the Medi-Cal Member will be notified within the 30-day period of the reason additional time is necessary. If Foundation's determination is to uphold the initial denial of coverage, the response to the Medi-Cal Member will include the Medi-Cal Member's right to request a hearing by Foundation's Member Grievance Committee, right to request a fair hearing by the Department of Health Services, or request disenrollment from Foundation.

B. The final internal level of appeal available to a Medi-Cal Member for resolution of a claim or request for prior authorization of coverage, is a hearing before Foundation's member Grievance Committee. Requests for a hearing must be in writing and received by Foundation within 90 days of Foundation's mailing of its determination on the first step grievance. Appeals received by Foundation after this period will not be considered and no further internal recourse is available.

Although the make-up of the Committee is subject to change at the discretion of Foundation, it is currently comprised of one Medi-Cal Member, a physician who has not previously been involved in the grievance, and Foundation's Medi-Cal Member Services Director or his or her designee. A quorum to convene a hearing is two of these persons.

Hearings will be scheduled within 30 days of written request and heard within 60 days of receipt, unless the Medi-Cal Member requests a later hearing date. Medi-Cal Members may appear with and have information offered by third parties, including attorneys, but not any persons having a conflict of interest with Foundation. Unless incapacitated or a minor, Medi-Cal Members must appear in person and are to be principally responsible for the presentation of their grievance and for direct response to questions by the Committee. The hearing is conducted as an informal administrative hearing -- formal rules of evidence and discovery which are common to legal hearings do not apply. In some cases, Foundation may require the hearing to be conducted by telephone conference.

III. EXTERNAL OPTIONS FOR GRIEVANCE RESOLUTION

A. A Medi-Cal Member may request a fair hearing from the Department of Health Services at any time during the grievance process, by contacting the Public Inquiry and Response Unit at (800) 952-5253, TDD (800) 952-8349.

B. If the Medi-Cal Member feels that no satisfactory resolution is possible, he or she may request disenrollment from Foundation by contacting the State's contractor, Health Choice, Inc., at (address and telephone number to be determined). Foundation may provide the Medi-Cal Member with a disenrollment form at his or her request, however, processing of the disenrollment form will be completed by Health Choice, Inc.

ADDENDUM I

COMPENSATION

1. Compensation. The following compensation rates shall apply for the period beginning with the date Foundation's Medi-Cal Plan for Los Angeles County commences and ending September 30, 1997. The below initial rates shall be adjusted in the same proportion and at the same time as the Monthly DHS Payments to Foundation are adjusted.

1.1 Molina's Compensation. Foundation shall pay to Molina for all Health Care Services and other services provided or arranged by Molina under this Agreement the following monthly Capitation Payment amounts for each Molina Member assigned by Foundation to Molina (based on the Molina Member's aid category):

FAMILY	AGED	DISABLED	CHILD	ADULT
$ [*]	$ [*]	$ [*]	$ [*]	$ [*]

In addition, Molina shall also exclusively enjoy all coordination of benefits recoveries and third party liability recoveries collected pursuant to Sections 2.05 and 2.06 of the Agreement.

1.2 Foundation's Compensation. In consideration for the services provided by Foundation pursuant to this Agreement and the Medi-Cal Agreement, Foundation will keep the balance of the Monthly DHS Payment for each Molina Member assigned by Foundation to Molina, as follows:

FAMILY	AGED	DISABLED	CHILD	ADULT
$ [*]	$ [*]	$ [*]	$ [*]	$ [*]

2. Due Date. Foundation shall make Capitation Payments as described in this Addendum on a monthly basis, due and payable within five (5) working days of Foundation's receipt of the corresponding payment from DHS.

3. Foundation Reinsurance. Foundation shall assume financial responsibility for any Health Care Services which exceed [*]% of the "estimated specified total expenditures" made by Molina under this Agreement. For the purposes of this provision, "estimated specified total expenditures" is defined as [*]% of DHS premium (excludes Molina's estimated profits of [*]% of the Monthly DHS Payment and Foundation's compensation of [*]% of the Monthly DHS Payment). Foundation will only pay for Health Care Services (i.e., not Molina's administrative expenses) if and to the extent the [*]% threshold of "estimated specified total expenditures" is exceeded on an "aggregate, annual" basis (i.e., the health care cost experience of all Molina Members over a one-

year period).

Reconciliation will occur once annually, four months after the close of each fiscal year, with incurred but not reported claims not considered after 90 days of the close of each 12-month contract period. For the purposes of this provision, "fiscal year" shall mean the period running annually from June 1 of one year through May 31 of the next year.

4. Retroactive Adjustments. If DHS determines that a Molina Member was improperly omitted from the Eligibility List for a period of time during which the Molina Member actually was eligible for Health Care Services, Foundation will pay Molina for the Molina Member for such time period at the Capitation Payment rate specified in this Addendum within five (5) working days of receiving the corresponding payment from DHS. If DHS determines that a Molina Member was improperly enrolled or should have been disenrolled in a prior month, Foundation will debit the Capitation Payment amount paid to Molina by the amount attributable to such Molina Member for such time period. Molina agrees that Foundation is not liable for any Capitation Payment amounts payable to or deductible from Molina's compensation amount due to any errors in the Eligibility List not caused by Foundation unless and except to the extent that DHS has recognized and corrected such errors, informed Foundation of the correct information, and made appropriate payment adjustments under the Medi-Cal Agreement.

5. Collection of Charges from Molina Members. Neither Molina nor any Molina Participating Provider shall in any event, including, without limitation, non-payment by Foundation, insolvency of Foundation, or breach of this Agreement, bill, charge, collect and deposit, or attempt to bill, charge, collect or receive form of payment, from any Molina Member for Health Care Services provided pursuant to this Agreement. Neither Molina nor any Molina Participating Provider shall maintain any action at law or equity against a Molina Member to collect sums owed by Foundation to Molina. Upon notice of any violation of this paragraph, Foundation may terminate this Agreement pursuant to Section 7.02(ii) and take all other appropriate action consistent with the terms of this Agreement to eliminate such charges, including, without limitation, requiring Molina, and Molina Participating Providers to return all sums improperly collected from Molina Members or their representatives.

Each contract between Molina and a Molina Participating Provider shall provide that in the event that Molina fails to pay the Molina Participating Provider, the Molina Member shall not be liable to the Molina Participating Provider for any sums owed by Molina.

In addition, Molina agrees to hold harmless the State of California and DHS in the event of non-payment by Foundation for Health Care Services provided to Molina Members.

Molina's obligations under this paragraph shall survive the termination of this Agreement with respect to Health Care Services provided during the term of this Agreement without regard to cause of termination of this Agreement.

6. Capitation Deposit Account. The parties shall establish an account (the "Account") at

a mutually acceptable bank for the purpose of protecting Molina in the event of Foundation's failure to make a Capitation Payment. The Account shall be established in accordance with the following guidelines:

6.1 Foundation shall deposit five (5) working days prior to the scheduled receipt of the first Capitation Payment from DHS an amount equal to the estimated Capitation Payment amount to Molina for the first month of the Agreement. Thereafter, Foundation shall adjust the Account by depositing additional amounts or withdrawing amounts so that, following the adjustment, the Account is equal to the most recent one month's Capitation Payment.

6.2 If Foundation fails to make Capitation Payments to Molina by the due date, Molina shall provide notice of non-payment to Foundation. If Foundation fails to make a payment in full within fifteen (15) days of the receipt of notice of non-payment, Molina may withdraw an amount from the Account equal to the delinquent amount of Capitation Payments due to Molina. Molina shall not be entitled to withdraw from the Account if Foundation, within the fifteen (15) day notice period, notifies Molina that it is contesting the claim for Capitation Payment and includes an explanation of Foundation's reason for contesting the Capitation Payment claim.

6.3 Following any permissible withdrawal from the Account by Molina, Foundation shall have fifteen (15) days to replenish the amount withdrawn from the Account. Failure to do so shall constitute breach of this Agreement.

6.4 Upon the effective date of termination of this Agreement, Molina shall be entitled to withdraw from the Account any delinquent Capitation Payments due from Foundation. Foundation shall be entitled to any remaining amounts in the Accounts upon the effective date of termination.

6.5 Except as provided in Sections 6.1 and 6.4 of this Addendum, Foundation shall have no ability to withdraw funds from the Account.

6.6 Except as provided in Sections 6.2 and 6.4 of this Addendum, Molina shall have no ability to withdraw funds from the Account.

6.7 Foundation shall be entitled to any and all interest earned on the Account. The parties understand and agree that the compensation arrangement under this Agreement is contingent upon the parties simultaneously entering into and maintaining separate similar subcontracts for Molina's Medi-Cal Agreements for Riverside and San Bernardino counties, whereunder the parties shall reverse the roles for the parties that are set out in this Agreement.

NOTICE OF AMENDMENT TO AGREEMENT REQUIRED BY
CALIFORNIA DEPARTMENT OF HEALTH SERVICES

REQUIRED MEDI-CAL SUBCONTRACT PROVISIONS

This is an amendment to the Health Services Agreement (the "Agreement") between Foundation Health, a California Health Plan ("Foundation") and Molina Medical Centers ("Provider"). For the purposes of this amendment, Foundation's Medi-Cal agreements with the California Department of Health Services ("DHS") and its subcontracts with Medi-Cal prepaid health plans, are hereinafter collectively referred to as the "PHP Agreement". Foundation has been directed by the DHS to amend its Medi-Cal participating provider agreements to include the below provisions which are required to appear in all subcontracts under the PHP Agreement by the terms of the PHP Agreement and by Medi-Cal law. The unilateral and generic form of this amendment is legally and administratively necessary because the language of this amendment may not be negotiated and because this amendment is being provided to many thousands of health care providers of different types (e.g., individual practitioners, medical groups, IPAs, facilities, ancillary providers, FQHCs, and subcontracting health plans), and these providers contract with Foundation under a variety of different forms of contracts. In accordance with the provision of the Agreement which provides that amendments required because of regulatory or legal requirements do not require the consent of Provider or Foundation, this amendment is effective immediately and is an integral part of the Agreement and shall supersede any contractual provisions to the contrary.

Foundation thanks you for your participation as an essential part of Foundation's Medi-Cal operations and we appreciate your understanding of this form of amendment.

All references to "Beneficiaries" in this amendment are deemed to refer to those Medi-Cal beneficiaries who are covered by Foundation under the PHP Agreement.

The Agreement is hereby amended to include the following provisions to the extent that such provisions do not appear in the Agreement:

1. Preparation and Retention of Records; Access to Records; Audits. Provider shall prepare and maintain medical and other books and records required by law in a form maintained in accordance with the general standards applicable to such book or record keeping. Provider shall maintain such financial, administrative and other records as may be necessary for compliance by Foundation with all applicable local, State, and federal laws, rules and regulations. Provider shall retain such books and records and all encounter data for a term of at least five years from the close of the California fiscal year in which the Agreement is in effect. Provider shall make Provider's books, records and encounter data pertaining to the goods and services furnished under the terms of the Agreement, available for inspection, examination or copying by Foundation, DHS, the United States Department of Health and Human Services ("DHHS"), the California

Department of Corporations ("DOC"), the United States Department of Justice ("DOJ"), and any other regulatory agency having jurisdiction over Foundation. The records shall be available at Provider's place of business, or at such other mutually agreeable location in California. When such entities request Provider's records, Provider shall produce copies of the requested records at no charge. Provider shall permit Foundation, and its designated representatives, and designated representatives of local, State, and federal regulatory agencies having jurisdiction over Foundation, to conduct site evaluations and inspections of Provider's offices and service locations. [22 CCR Section 53250(e)(l); W & I Section 14452(c);PHP Agreement]

2. Governing Law. The Agreement shall be governed by and construed and enforced in accordance with all laws, regulations and contractual obligations incumbent upon Foundation. Provider shall comply with all applicable local, State, and federal laws, rules and regulations, now or hereafter in effect, to the extent that they directly or indirectly affect Provider or Foundation, and bear upon the subject matter of the Agreement. Provider shall comply with the provisions of the PHP Agreement, and Chapters 3 and 4 of Subdivision 1 of Division 3 of Title 22 of the California Code of Regulations. In addition, Foundation is subject to the requirements of Chapter 2.2 of Division 2 of the California Health and Safety Code and Subchapter 5.5 of Chapter 3 of Title 10 of the California Code of Regulations. Any provision required to be in the Agreement by either of the above laws shall bind the parties whether or not provided in the Agreement. [22 CCR Section 53250(c)(2)]; W & I Section 14452(a); Knox-Keene Act]

3. Amendments. Amendments to the Agreement shall be submitted by Foundation to the DHS for prior approval at least 30 days before the effective date of any proposed changes governing compensation, services or term. Proposed changes, which are neither approved nor disapproved by the Department, shall become effective by operation of law 30 days after the DHS has acknowledged receipt, or upon the date specified in the amendment, whichever is later. Subcontracts between a prepaid health plan and a subcontractor shall be public records on file with the DHS. [22 CCR Sections 53250(a), (c)(3), & (e)(4); W & I Section 14452(a)]

4. Provider's Notice to DHS Upon Termination. Provider shall notify the DHS in the event that the subcontract is amended or terminated. Notice to the DHS is considered given when properly addressed and deposited in the United States Postal Service as first- class registered mail, postage attached. [Knox-Keene Act and PHP Agreement]

5. Notice of Change in Availability or Location of Covered Services. Foundation is obligated to ensure Beneficiaries are notified in writing of any changes in the availability or location of Covered Services at least 30 days prior to the effective date of such changes, or within 14 days prior to the change in cases of unforeseeable circumstances. Such notifications must be approved by DHS prior to the release. In order for Foundation to meet this requirement, Provider is obligated to notify Foundation in writing of any

changes in the availability or location of Covered Services at least 40 days prior to the effective date of such changes. [Knox-Keene Act and PHP Agreement]

6. Reports and Information. Provider shall provide Foundation, within the time requested by Foundation, with all such reports and information as Foundation may require to allow it to meet the reporting requirements under the PHP Agreement or any applicable law, rule or regulation. [22 CCR Section 53250(c)(5)]

7. Subcontracting Under the Agreement. Provider shall not subcontract for the performance of services under the Agreement without the prior written consent of Foundation. Every such subcontract shall provide that it is terminable with respect to Beneficiaries by Provider upon Foundation's request. Provider shall furnish Foundation with copies of such subcontracts, and amendments thereto, within ten days of execution. Each such subcontracting provider shall meet Foundation's credentialing requirements, prior to the subcontract becoming effective. Provider shall be solely responsible to pay any health care provider permitted under the subcontract, and shall hold, and ensure that health care providers hold, Foundation, Beneficiaries and the State harmless from and against any and all claims which may be made by such subcontracting providers in connection with services rendered to Beneficiaries under the subcontract. Provider shall maintain and make available to Foundation, DHS, DHHS, DOC, DOJ, and any other regulatory agency having jurisdiction over Foundation, copies of all Provider's subcontracts under the Agreement and to ensure that all such subcontracts are in writing and require that the subcontractor: (1) make all applicable books and records available for inspection, examination or copying by said entities; (2) retain such books and records for a term of at least five years from the close of the fiscal year in which the subcontract is in effect; and (3) maintain such books and records in a form maintained in accordance with the general standards applicable to such book or record keeping. [22 CCR Section 53250(e)(3)]

8. Beneficiaries and State Held Harmless. Provider agrees that in no event, including, but not limited to, non-payment by Foundation, the insolvency of Foundation, or breach of the Agreement, shall Provider or a subcontractor of Provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against Beneficiaries, the State of California, or persons other than Foundation acting on their behalf for services provided pursuant to the Agreement. Provider further agrees that: (1) this provision shall survive the termination of the Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of Beneficiaries; and (2) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and Beneficiaries or persons acting on their behalf. Any modification, addition, or deletion of or to the provisions of this clause shall be effective on a date no earlier than 15 days after the State regulatory agency has received written notice of such proposed change and has approved such change. [22 CCR Section 53250(e)(6)]

9. Transfer of Care Upon Termination of the Agreement. Provider shall, pursuant to the requirements of the PHP Agreement, assist in the orderly transfer of care of all Beneficiaries under the care of Provider in the event of the termination of the Agreement. [Knox-Keene Act and PHP Agreement]

10. Assignment and Delegation. Assignment or delegation of the Agreement shall be void unless prior written approval is obtained from the DHS. In addition, any assignment or delegation of the Agreement by Provider shall be void unless prior written approval is obtained from Foundation. [22 CCR Section 53250(e)(5)]

11. Beneficiary Education. Provider shall make health education materials and programs available to Beneficiaries on the same basis that it makes such materials and programs available to the general public, and shall use its best efforts to encourage Beneficiaries to participate in such health education programs. [PHP Agreement]

12. Grievances. Provider and Foundation agree to cooperate in resolving all grievances relating to the provision of services to Beneficiaries. Provider shall comply with Foundation's grievance procedure, including any fair hearing procedure involving the State of California or Foundation. Provider shall abide by, and implement upon request, all Foundation, DHS and DOC determinations on Beneficiary appeals and grievances. If Provider fails to implement a determination of Foundation, DHS or DOC in a timely manner, Foundation may arrange and cover the disputed service or remedy the grievance to the reasonable satisfaction of the Beneficiary and offset the cost of same from Foundation's payment under the Agreement to Provider. Copies of complaint forms and Foundation's grievance procedure will be made available to Provider and all Beneficiaries. Provider shall provide a Foundation complaint form to a Beneficiary who wishes to register a written complaint. Provider shall report any Beneficiary complaint directly to Foundation within one business day of receipt, whether resolved directly or not. All Beneficiary complaints will be logged by Foundation, a form letter acknowledging the complaint will be sent to the Beneficiary within five days of its receipt, and resolve the complaint within 30 days or document reasonable efforts to resolve the complaint. Beneficiaries may request disenrollment from Foundation or may request a fair hearing from the California Department of Social Services. [Section 1368 of the Knox-Keene Act and PHP Agreement]

13. Provider-Patient Relationship. Provider shall be solely responsible, without interference from Foundation or its agent, for providing health care to Beneficiaries, and shall have the right to object to treating any individual who makes onerous the relationship between Provider and Beneficiary. In the event of a breakdown in such relationship, Foundation shall make reasonable efforts to assign the Beneficiary to another participating provider. If reassignment is unsuccessful, a request may be filed with the DHS to permit termination of services to such Beneficiary. Approval from the DHS must be obtained before Provider terminates services to such Beneficiary. Provider and Foundation are

independent contractors in relation to each other and each party is responsible for its own acts. [PHP Agreement]

14. Fair Employment Requirements. During the term of the Agreement, Provider and its subcontractors shall not unlawfully discriminate against any employee or applicant for employment because of race, religious creed, color, national origin, ancestry, physical disability, mental disability, medical condition, marital status, age (over 40) or sex. Provider and its subcontractors also shall ensure that the evaluation and treatment of their employees and applicants for employment are free of such discrimination. Provider and its subcontractors shall comply with the provisions of the Fair Employment & Housing Act (California Government Code Section 12990 et seq.) and the applicable regulations promulgated thereunder (2 CCR Section 7285.0 et seq.). The applicable regulations of the Fair Employment & Housing Commission implementing Government Code Section 12990, set forth in Chapter 5 of Division 4 of Title 2 of the California Code of Regulations are incorporated into the Agreement by reference and made a part hereof as if set forth in full. Provider and its subcontractors shall give written notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreements. [PHP Agreement]

15. Confidentiality of Information. Names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with Title 45, Code of Federal Regulations, Sections 205.50 & 14100.2 of the California Welfare and Institutions Code and the regulations adopted thereunder. For the purposes of the Agreement, all information, records, data, and data elements collected and maintained for or in connection with performance under the Agreement and pertaining to Beneficiaries shall be protected by Provider from unauthorized disclosure. With respect to any identifiable information concerning a Beneficiary under the Agreement that is obtained by Provider or its subcontractors, Provider: (1) will not use any such information for any purpose other than carrying out the express terms of the Agreement; (2) will promptly transmit to Foundation all requests for disclosure of such information; (3) will not disclose, except as otherwise specifically permitted by the Agreement, any such information to any party other than Foundation without Foundation's prior written authorization specifying that the information is releasable under applicable law; and (4) will, at the expiration or termination of the Agreement, return all such information to Foundation or maintain such information according to written procedures provided Provider by Foundation for this purpose. Provider shall ensure that its subcontractors comply with the provisions of this provision. [PHP Agreement]

16. Third Party Tort Liability. Provider shall make no claim for recovery for health care services rendered to a Beneficiary when such recovery would result from an action involving the tort liability of a third party or casualty liability insurance, including workers' compensation awards and uninsured motorist coverage. Within five days of discovery, Provider shall notify Foundation of cases in which an action by the Beneficiary

involving the tort or workers' compensation liability of a third party could result in a recovery by the Beneficiary. Provider shall promptly provide: (1) all information requested by Foundation in connection with the provision of health care services to a Beneficiary who may have an action for recovery from any such third party; (2) copies of all requests by subpoena from attorneys, insurers or Beneficiaries for copies of bills, invoices or claims for health care services; and (3) copies of all documents released as a result of such requests. Provider shall ensure that its subcontractors comply with the requirements of this provision. [PHP Agreement]

17. Non-Discrimination. Provider shall not discriminate against any Beneficiary in the provision of Contracted Services hereunder, whether on the basis of the Beneficiary's coverage, age, sex, marital status, sexual orientation, race, color, religion, ancestry, national origin, disability, handicap, health status, source of payment, utilization of medical or mental health services or supplies or other unlawful basis including, without limitation, the filing by such Beneficiary of any complaint, grievance or legal action against Provider, Foundation, or an affiliate or subcontractor of Foundation. [Knox-Keene Act and PHP Agreement]

18. Encounter Reporting. For Beneficiaries for which Provider may receive capitation compensation under the Agreement, Provider shall provide Foundation with the following information, via personal computer diskette, magnetic tape or electronic transmission in standard HCFA 1500 form or its successor format and hardcopy, for each encounter with a Beneficiary during a calendar month. Such electronic encounter information and hardcopy materials shall be complete, accurate and provided to Foundation by the 15th day of the month following the month in which the encounter occurred. Encounter reporting shall be in accordance with, but not limited to, the Health Plan Employer Data and Information Set (HEDIS), Version 2.0, or its successor. Additionally, Provider shall promptly provide Foundation with all corrections to and revisions of such encounter data. [PHP Agreement]

19. No Surcharges and No Copayments. Provider shall not charge a Beneficiary any fee, surcharge or Copayment for health care services rendered pursuant to the Agreement. In addition, Provider shall not collect a sales, use or other applicable tax from Beneficiaries for the sale or delivery of medical services. If Foundation receives notice of any additional charge, Provider shall fully cooperate with Foundation to investigate such allegations, and shall promptly refund any payment deemed improper by Foundation to the party who made the payment. [Knox-Keene Act and PHP Agreement]

NOTE: THE FOLLOWING PROVISIONS ARE NON-STANDARD AND UNIQUE TO MOLINA MEDICAL CENTERS.

20. Striking of Inaccurate Default Enrollment Provision. Addendum E in the Agreement contains certain inaccurate language concerning the enrollment process of the State and

inaccurate language concerning members being required to select a primary hospital. Addendum E is hereby deleted in its entirety and replaced with the restated Addendum E attached hereto as Attachment 1.

21. No Automatic Rate Adjustment Commensurate With DHS Rate Adjustment to Foundation. The second sentence in Section 1 of Addendum I to the Agreement concerning the automatic adjustment in rates commensurate with adjustments in Foundation's rate from the DHS, has been determined by the DHS to be impermissible and is hereby stricken. If the parties are unable to mutually agree on a rate adjustment under the circumstances of Foundation's rate from the DHS being adjusted, then either party may terminate the Medi-Cal line of business under the Agreement with 30 days' written notice. Section 1.2 of Addendum I to the Agreement is also hereby stricken.

FOUNDATION HEALTH, A CALIFORNIA HEALTH PLAN

By: /s/

David J. Friedman
Vice President
Medi-Cal Operations

ATTACHMENT 1 TO AMENDMENT

RESTATED ADDENDUM E

PROCEDURE FOR ASSIGNMENT OF FOUNDATION'S LOS ANGELES COUNTY MAINSTREAM MEDI-CAL MEMBERS AMONG FOUNDATION, MOLINA MEDICAL CENTERS AND UCHP

Prepaid Health Plan Enrollees. If a Medi-Cal beneficiary was a Medi-Cal prepaid health plan enrollee of Foundation, Molina or Universal immediately prior to the commencement of operations for the Two Plan Model in Los Angeles County, Foundation will assign the Medi-Cal beneficiary to such plan, unless prohibited by the DHS or otherwise requested by the Medi-Cal beneficiary.

Assignment of a Medi-Cal Member Who Selects a PCP Unique to One of the Three Plans. Los Angeles County Medi-Cal beneficiaries who select or who are assigned by the enrollment contractor to Foundation's mainstream plan will be offered the opportunity to select their Primary Care Physician from a single listing of Foundation, Molina and Universal Primary Care Physicians. If the Medi-Cal Member selects or is assigned to a Primary Care Physician that contracts with only one of the three plans, such health plan will be responsible for the arrangement of Health Care Services for the Medi-Cal Member, but the Medi-Cal Member remains a Medi-Cal Member of Foundation.

Assignment of a Medi-Cal Member Who Either Selects a PCP of Two or Three of the Plans or Who Does Not Select a PCP. If a Medi-Cal Member selects a Primary Care Physician that contracts with two or three of the plans, or the Medi-Cal Member does not select a Primary Care Physician at the time of enrollment, the Medi-Cal Member will be assigned by Foundation to one of the plans on a rational, fair and alternating basis. In making this assignment, Foundation will consider the ability of the plans' available Primary Care Physicians to accommodate the geographic and linguistic needs of the Medi-Cal Member. Where the geographic and linguistic needs of the Medi-Cal Member can be adequately served by Primary Care Physicians of two or more of the plans, Foundation will assign the Medi-Cal Member to the plan which is next due for an assignment on an alternating basis among the three plans.

If a Medi-Cal Member selects a Primary Care Physician that contracts with Molina and Universal, the Medi-Cal Member will be assigned by Foundation to Molina or Universal on a rational, fair and alternating basis.

This forementioned assignment procedure will also apply to Medi-Cal Members who request a Primary Care Physician change but who do not indicate the name of a new Primary Care Physician.

Additionally, if a Medi-Cal Member selects a PCP that contracts with two or three of the plans but requests in writing to be assigned to one of such plans, Foundation will assign the

Medi-Cal Member to the requested plan. However, the parties understand and agree that such assignments to Molina and Universal shall only be made until Molina and Universal reach the 26% enrollment limitation described in this Addendum below.

Enrollment Limitation for Molina and Universal. This assignment process will continue until Molina and Universal each achieve a total Medi-Cal membership in Los Angeles County of 26% of the total number of Foundation Medi-Cal Members in Los Angeles County (Foundation will calculate enrollment numbers on a monthly basis). When Molina or Universal achieve such enrollment, these plans will only receive new Medi-Cal Members if they are the sole plan that contracts with the Primary Care Physician selected by the Medi-Cal Member.

If any of the plans is unable to service additional Medi-Cal Members due to lack of capacity, Foundation will assign additional Medi-Cal Members to the remaining plans with capacity using the above procedure.

AMENDMENT OF
HEALTH NET-MOLINA LOS ANGELES COUNTY MEDI-CAL AGREEMENT

This is an amendment of the Health Services Agreement for Los Angeles County (the "Agreement") entered into by and between Molina Medical Centers ("Molina") and Health Net (formerly, Foundation Health, a California Health Plan). This Amendment is an integral part of the Agreement and shall supersede any contractual provisions to the contrary. The parties hereby amend the Agreement as follows:

1. Revised compensation arrangement. Addendum I is deleted in its entirety and replaced with the restated Addendum I attached hereto as Exhibit 1.

MOLINA MEDICAL CENTERS	HEALTH NET
By: /s/	By: /s/
George Goldstein, President	Jeffrey A. Baumeister, Vice President California Health Programs
Date: 9/22/99	Date: 9/22/99

EXHIBIT 1 TO AMENDMENT OF
HEALTH NET-MOLINA LOS ANGELES COUNTY MEDI-CAL AGREEMENT

RESTATED ADDENDUM I

COMPENSATION

1. Compensation. Health Net shall pay to Molina for all Health Care Services and other services provided or arranged by Molina under this Agreement the following monthly Capitation Payment amounts for each Member assigned by Health Net to Molina (based on the Member's aid category).

1.1 Compensation for the period of July 1,1997 to October 1,1997. For the period of July 1, 1997 to October 1,1997, Health Net shall pay Molina the monthly "Amended Rates" set out below for each Member assigned by Health Net to Molina. The parties understand and agree that Health Net will make the specified "adjustment" to the specified "Previously Paid Rates" to pass on an approximate [*]% rate increase.

PREVIOUSLY PAID RATE		AMENDED RATE	ADJUSTMENT
Family	[*]	[*]	[*]
Child	[*]	[*]	[*]
Disabled	[*]	[*]	[*]
Aged	[*]	[*]	[*]
Adult	[*]	[*]	[*]

1.2 Compensation for the period of October 1,1997 to April 1,1998. For the period of October 1,1997 to April 1,1998, Health Net shall pay Molina the monthly "Amended Rates" set out below for each Member assigned by Health Net to Molina. The parties understand and agree that Health Net made the specified "adjustment" to the specified "Previously Paid Rates" to adjust the rates to the specified "Amended Rates".

PREVIOUSLY PAID RATE		AMENDED RATE	ADJUSTMENT
Family	[*]	[*]	[*]
Child	[*]	[*]	[*]
Disabled	[*]	[*]	[*]
Aged	[*]	[*]	[*]
Adult	[*]	[*]	[*]
AIDS	[*]	[*]	[*]

AIDS compensation. Payment of the AIDS rate is payable after Health Net receives its

AIDS compensation from the DHS, and will be reduced to the extent that Molina has received another capitation rate from Health Net.

1.3 Compensation for the period of April 1,1998 to October 1,1998. For the period of April 1, 1998 to October 1,1998, Health Net shall pay Molina the monthly "Amended Rates" set out below for each Member assigned by Health Net to Molina. The parties understand and agree that Health Net made the specified "adjustment" to the specified "Previously Paid Rates" to pass on a similar rate reduction in Health Net's compensation from the DHS for a carve out of optical lenses under the Medi-Cal Agreement.

PREVIOUSLY PAID RATE		AMENDED RATE	ADJUSTMENT
Family	[*]	[*]	[*]
Child	[*]	[*]	[*]
Disabled	[*]	[*]	[*]
Aged	[*]	[*]	[*]
Adult	[*]	[*]	[*]
AIDS	[*]	[*]	[*]

AIDS compensation. Payment of the AIDS rate is payable after Health Net receives its AIDS compensation from the DHS, and will be reduced to the extent that Molina has received another capitation rate from Health Net.

1.4 Compensation for the period of October 1,1998 to July 1,1999. For the period of October 1,1998 to July 1,1999, Health Net shall pay Molina the monthly "Amended Rates" set out below for each Member assigned by Health Net to Molina.

PREVIOUSLY PAID RATE		AMENDED RATE	ADJUSTMENT
Family	[*]	[*]	[*]
Child	[*]	[*]	[*]
Disabled	[*]	[*]	[*]
Aged	[*]	[*]	[*]
Adult	[*]	[*]	[*]
AIDS	[*]	[*]	[*]

1.5 Compensation for the period of July 1,1999 to October 1,1999. For the period of July 1, 1999 to October 1, 1999, Health Net shall pay Molina the monthly "Amended Rates" set out below for each Member assigned by Health Net to Molina.

Family	[*]
Child	[*]
Disabled	[*]

Aged [*]
Adult [*]
AIDS [*]

1.6 Compensation Adjustment Provision. Subject to the prior written approval of this provision by the DHS, in the event that Health Net's compensation for its Los Angeles County Medi-Cal Plan under Health Net's Medi-Cal Agreement with the DHS is adjusted, Health Net and Molina will execute an amendment of this Agreement that establishes revised per member per month capitation rates that are commensurate with the new Medi-Cal rates paid by the DHS, less [*]% and the $ [*] per member per month reduction described in Section 6below,

1.7 Incentive Withhold Arrangement. Commencing April 1, 1999, Health Net shall withhold $ [*] each month from Molina's compensation under this Agreement to incent Molina's efforts to assist Health Net in receiving incentive monies withheld from Health Net by the DHS that are tied to Health Net's achievement of specified utilization standards, as measured by encounter data and PM-160 information, and the achievement of timely encounter data and PM-160 reporting. The performance standards, terms and conditions for Health Net's receipt of its monies withheld by the DHS (the "DHS Withhold of Health Net Money") are set out in the previously provided ten-page excerpt of the Medi-Cal Agreement that is summarized below. The terms, conditions and performance standards for Molina's receipt of its incentive monies withheld by Health Net shall be identical to the terms, conditions and performance standards for Health Net's receipt of its incentive monies withheld by the DHS, except as otherwise set out in this Compensation Addendum. The parties agree that the terms, conditions and performance standards for Molina's receipt of its incentive monies withheld by Health Net shall be automatically modified to conform with any DHS modifications of the terms, conditions and performance standards of the DHS Withhold of Health Net Money.

The amount of any distribution of the Molina withhold will be determined by Health Net in its sole discretion based on all of the following factors:

1. The extent of Molina's compliance with the DHS performance standards and the terms and conditions of this Agreement,

2. The amount of any return of the DHS Withhold of Health Net Money, and Molina's relative share considering the total incentive monies at stake of the following three "Plan Partners" that collectively serve Health Net's Los Angeles County. Medi-Cal Plan (Molina, Universal Care Health Plan and Health Net), and

3. The combined performance of the Plan Partners against the performance standards. That is, the DHS performance standards consider the collective utilization of all members of Health Net's Los Angeles County Medi-Cal Plan and the totality of PM-160 and encounter data reporting under the plan, even though each of the Plan Partners are only responsible

for the arrangement of health care services and related PM-160 and encounter data reporting for a portion of the members. The return of incentive withhold monies of each of the Plan Partners is dependent on the collective performance of the Plan Partners against the performance standards. For example, if Molina significantly falls short of the performance standards, it will jeopardize the return of its $ [*] share of the withhold, and will jeopardize the return of $ [*] share of the withhold of its three Plan Partners. Hence, the risk of the return of our respective withhold monies must necessarily be shared on a mutually dependent basis.

In order for Health Net to meet the performance standard of encounter data reporting timeliness, Molina shall produce encounter data to Health Net 30 days' prior to the time that Health Net is required to report the data to the DHS.

Summary of terms, conditions and performance standards of DHS Withhold of Health Net Money. This Section sets out a very general summary of some of the terms, conditions and details of the very complex DHS Withhold of Health Net Money. The actual provisions are set out in the previously provided ten-page excerpt of the Medi-Cal Agreement that is summarized below.

Applicable member population;	Health Net's Los Angeles County Medi-Cal Members
Withhold amount:	$ [*] each month
Performance standards, means of measurement, and portion of withhold:	1. Children Served. 30% of children receive CHDP services, as measured by PM-160 information. This standard constitutes 35% of the withhold or $ [*]
	2. Outpatient and Emergency Room Services. For the period of July 1, 1998 - June 30, 1999, 1,380 member encounters receive outpatient or emergency department services for every 1,000 members. For the period of July 1, 1999 - June 30, 2000, 1,822 member encounters receive outpatient or emergency department services for every 1,000 members). This standard is measured by outpatient and emergency room encounter data and constitutes 35% of the withhold or $ [*]

3. Timeliness of PM-160 Reporting of Children Served. 75% of all PM-160 information for children served is submitted within 30 days after the end of the month of the encounter. This standard constitutes 15% of the withhold or $ [*]

4. Timeliness of Encounter Data Reporting of Outpatient and Emergency Room Services. 70% of outpatient and emergency room data is submitted within 90 days after the end of the month of the encounter. This standard constitutes 15% of the withhold or $ [*]

GRADUATED DISTRIBUTION FOR PARTIAL COMPLIANCE -WITH FIRST TWO STANDARDS	% OF COMPLIANCE	% OF WITHHOLD RETURNED
	100%	100%
	76-99%	75%
	51-75%	50%
	26-50%	25%
	0-25%	0%

Timing of distribution of withhold — 9-12 months after completion of each quarter

1.8 FQHC and RHC Risk Corridor. Beginning October 1,1997 and through June 30, 1999, the DHS shall perform reconciliations to determine the variance between the funds that have been paid to Health Net in its Los Angeles County capitation rates to reflect the dollar value of Federally Qualified Health Centers ("FQHC") and Rural Health Clinics ("RHC") interim rate payments made to these entities in Los Angeles County under the Medi-Cal Fee-For-Service Program and the amount of payments to contracting FQHCs and RHCs under Health Net's Los Angeles County Medi-Cal Plan. For each reconciliation, if under Health Net's Los Angeles County Medi-Cal Plan contracting FQHCs and RHCs have been paid in the aggregate an amount greater than [*]% of the dollar value of FQHC and RHC interim rate payments included in Health Net's Los Angeles County capitation rates, DHS shall pay Health Net the amount in excess of [*]%. For each reconciliation, if under Health Net's Los Angeles County Medi-Cal Plan contracting FQHCs and RHCs have been paid in the aggregate an amount less than [*]% of the dollar value of FQHC and RHC interim rate payments included in Health Net's Los Angeles County capitation rates, Health Net is required to refund the amount below [*]% to the DHS.

If Health Net receives an FQHC/RHC Risk Corridor payment from the DHS, Health Net shall

distribute to Molina its share. If Health Net is required to make an FQHC/RHC Risk Corridor payment to the DHS, Health Net shall deduct Molina's share from its compensation under this Agreement. The amount of any such payment to, or deduction from, Molina will be reasonably determined by Health Net based on Molina's share of FQHC and RHC payments relative to all FQHC and RHC payments under Health Net's Los Angeles County Medi-Cal Plan.

2. Health Net Reinsurance. Health Net shall assume financial responsibility for any Health Care Services rendered to Members assigned to Molina that exceed [*]% of the amount of Capitation Payments to Molina under this Agreement over a one-year fiscal year period of June 1 of one year through May 31 of the next year. Health Net will only pay for Health Care Services, not Molina's administrative expenses. Reconciliation will occur once annually. four months after the close of each fiscal year, with incurred but not reported claims not considered after 90 days of the close of each 12-month contract period.

3. Retroactive Enrollment Adjustments. If DHS determines that a Member was improperly omitted from the Eligibility List for a period of time during which the Member actually was eligible for Health Care Services, Health Net will pay Molina for the Member for such time period at the Capitation Payment rate specified in this Addendum within five working days of receiving the corresponding payment from DHS. If DHS determines that a Member was improperly enrolled or should have been disenrolled in a prior month, Health Net will debit the Capitation Payment amount paid to Molina by the amount attributable to such Member for such time period. Molina agrees that Health Net is not liable for any Capitation Payment amounts payable to or deductible from Molina's compensation amount due to any errors in the Eligibility List not caused by Health Net unless and except to the extent that DHS has recognized and corrected such errors, informed Health Net of the correct information, and made appropriate payment adjustments under the Medi-Cal Agreement.

4. Collection of Charges From Members. Neither Molina nor any Molina Participating Provider shall in any event, including, without limitation, non-payment by Health Net, insolvency of Health Net, or breach of this Agreement, bill, charge, collect and deposit, or attempt to bill, charge, collect or receive form of payment, from any Member for Health Care Services provided pursuant to this Agreement. Neither Molina nor any Molina Participating Provider shall maintain any action at law or equity against a Member to collect sums owed by Health Net to Molina. Upon notice of any violation of this paragraph, Health Net may terminate this Agreement pursuant to Section 7.02(ii) and take all other appropriate action consistent with the terms of this Agreement to eliminate such charges, including, without limitation, requiring Molina, and Molina Participating Providers to return all sums improperly collected from Members or their representatives.

Each contract between Molina and a Molina Participating Provider shall provide that in the event that Molina fails to pay the Molina Participating Provider, the Member shall not be liable to the Molina Participating Provider for any sums owed by Molina. In addition,

Molina agrees to hold harmless the State of California and DHS in the event of non-payment by Health Net for Health Care Services provided to Members. Molina's obligations under this Section shall survive the termination of this Agreement with respect to Health Care Services provided during the term of this Agreement without regard to cause of termination of this Agreement.

5. Right to reduce compensation and/or dedelegate to the extent that Molina has not performed its responsibilities under this Agreement. Pursuant to the Agreement, Health Net has delegated the performance of certain functions to Molina. In the event Health Net concludes that Molina is failing to materially perform a delegated function to Health Net's satisfaction, Health Net may dedelegate that function and/or reduce Molina's compensation by an actuarially or financially determined amount, subject to the following:

5.1 Health Net shall first provide to Molina a detailed written notification of Health Net's determination that Molina has materially failed to perform the delegated function. Health Net's written notification shall also include an actuarial or financial analysis of the amount by which Health Net will reduce Molina's compensation.

5.2 Molina shall have 30 days from the date of receipt of the aforementioned written notification, or such longer period as Health Net may identify in that notification, to demonstrate that Molina is materially performing the delegated function to Health Net's satisfaction (i.e., full performance of the contract requirement). If Molina does so within that time frame, the delegated function shall remain with Molina. If Molina is unable to do so within that time frame, the function may be dedelegated and/or Health Net may make an appropriate reduction in compensation retroactive to the date of material nonperformance. In addition, if Molina cures the nonperformance of a delegated responsibility within the 30-day cure period, Health Net may make an appropriate reduction in compensation for the period of material nonperformance.

6. Reduction for nonperformance of credentialing, primary care site review and medical record audit responsibilities under this Agreement. Due to Health Net's dedelegation of Molina for credentialing responsibilities, Molina's compensation shall be reduced by $ [*] per Member per month. Such reduction shall apply prospectively and retroactively to October 1, 1997.

AMENDMENT OF
HEALTH NET-MOLINA LOS ANGELES COUNTY MEDI-CAL AGREEMENT

This is an amendment of the Health Services Agreement for Los Angeles County (the "Agreement") entered into by and between Molina Healthcare of California (formerly, "Molina Medical Centers") and Health Net of California, Inc. (formerly, "Foundation Health, a California Health Plan"). Subject to the terms and conditions of Restated Addendum I to the Agreement, the parties hereby amend the Agreement as follows:

1. Revised compensation arrangement for the period of August 1, 2000 through September 30,2000. For the specified period, Health Net shall pay Molina the following monthly capitation rates for each Member assigned to Molina:

Family	[*]
Child	[*]
Disabled	[*]
Adult	[*]
Aged	[*]
AIDS	[*]

2. Revised compensation arrangement for the period of October 1, 2000 through September 30, 2001. For the specified period, Health Net shall pay Molina the following monthly capitation rates for each Member assigned to Molina:

Family	[*]
Child	[*]
Disabled	[*]
Adult	[*]
Aged	[*]
AIDS	[*]

3. Effective date of Amendment. This Amendment is effective August 1, 2000.

MOLINA/HEALTHCARE
OF CALIFORNIA

By: /s/

George Goldstein,
President

HEALTH NET OF CALIFORNIA, INC.

By: /s/

Dave Meadows,
Vice President
California Health Programs

AMENDMENT OF
HEALTH NET-MOLINA MEDI-CAL HEALTH SERVICES AGREEMENT
FOR LOS ANGELES COUNTY

CONFORMATION OF PREEXISTING UTILIZATION MANAGEMENT DELEGATION AGREEMENT IN COMPLIANCE WITH NCQA STANDARDS

This is an amendment of the Health Services Agreement for Los Angeles County (the "Agreement") entered into by and between Molina Healthcare of California ("Molina") and Health Net of California, Inc. ("Health Net"). This amendment is to (1) confirm and clarify compliance of the Agreement with the NCQA utilization management delegation standards, and (2) clarify delegation responsibilities concerning utilization management of pharmaceutical services.

The parties hereby amend the Agreement as follows:

1. Addition of Addendum J to each Agreement. The language attached as Exhibit 1 to this Amendment is hereby added as Addendum J to the Agreement.

2. Effective date of Amendment. This Amendment is effective June 1, 2001.

MOLINA HEALTHCARE OF CALIFORNIA	HEALTH NET OF CALIFORNIA, INC.
By: /s/	By: /s/
George Goldstein, President	Dave Meadows, Vice President California Health Programs

EXHIBIT 1 TO AMENDMENT OF
HEALTH NET-MOLINA MEDI-CAL HEALTH SERVICES AGREEMENT
FOR LOS ANGELES COUNTY

ADDENDUM J

CONFIRMATION OF PREEXISTING UTILIZATION MANAGEMENT DELEGATION AGREEMENT IN COMPLIANCE WITH NCQA STANDARDS

When the parties entered into the Agreement in 1996, the party holding the Medi-Cal contract with the DHS for the county ("Medi-Cal Plan") delegated to the subcontracting party ("Subcontracting Plan") both the right and duty to perform utilization management functions, including pharmaceutical utilization management, with respect to Medi-Cal Plan members who are assigned to the Subcontracting Plan. In Los Angeles County, Health Net is the Medi-Cal Plan and Molina is the Subcontracting Plan. The Agreement and the delegation provisions therein were approved by the California Department of Health Services ("DHS"), HCFA and the California Department of Managed Health Care. The delegation of utilization management functions under the Agreement to the Subcontracting Plan has been successfully operative for more than five years without adverse incident.

Although neither party is presently accredited by NCQA, each is, nonetheless, obligated to comply with essentially all NCQA standards pursuant to their Medi-Cal contracts with the DHS, and certain Medi-Cal and Knox-Keene laws. In accordance with a study prepared by NCQA and published in the January 2001 report entitled "Medi-Cal Audit Crosswalk: A Comparison of the NCQA Accreditation Standards and Medi-Cal Regulatory Oversight Requirements for Managed Care Organizations", both NCQA and the DHS found that NCQA standards are consistent with existing Medi-Cal Plan Contract and legal requirements. In particular, NCQA and the DHS found that the NCQA standard UM 13 for delegation of utilization management functions (renumbered UM 15 for the NCQA Guidelines that are effective July 1, 2001) is consistent with the following sections of the Medi-Cal Plan's Contract with the DHS: Sections 3.27.1, 3.27.2, 6.5.2.6, Delegation of QIP Activities, 6.5.2.6(A), Maintenance of policies and procedures which describe delegated activities, 6.5.2.6(B), Establish reporting standards, 6.5.2.6(C), Continues monitoring and evaluation of the delegated functions, 6.5.2.6(D), Assurance and documentation that subcontractor has the administrative capacity, task experience, and budgetary resources to fulfill its responsibilities. NCQA and the DHS also found that the NCQA delegation standard is consistent with 10 CCR 1300.70(b)(2)(B-C), and (G)(2-4). This NCQA-Medi-Cal Plan contract consistency is not coincidental because beginning in 1996, the DHS began to issue new, and amend existing, Medi-Cal plan contracts to conform with NCQA requirements.

The described NCQA report also found NCQA standards UM 3-6 were consistent with and set out in the following sections of each of the Medi-Cal Plan's contracts with the DHS and specified law:

- NCQA and the DHS found that NCQA standard UM 3 is consistent with Medi-Cal Plan Contract Section 6.5.9.3(A) and California Health and Safety Code Sections 1367.01(e)and 1367(g).
- NCQA and the DHS found that NCQA standard UM 4 is consistent with Medi-Cal Plan Contract Sections 6.5.9.3(E), 6.9.14 and California Health and Safety Code Sections 1367.0l(h)(1-4), and 1367.10(h)(2).
- NCQA and the DHS found that NCQA standard UM 5 is consistent with Medi-Cal Plan Contract Section 6.5.9.1 and California Health and Safety Code Sections 1367.5(a), and 1367(g).
- NCQA and the DHS found that NCQA standard UM 6 is consistent with Two-Plan Model Contract Sections 6.5.9.3(A), 6.9.14, 22 CCR 53894, 22 CCR 51014.1, and California Health and Safety Code Sections 1367.0l(h)(4), and 1368(a)(4).

The NCQA standards in each of the Medi-Cal Plan's contracts with the DHS were, in turn, set out in the following sections of the Agreements to conform with the delegation and oversight requirements in the parties' Medi-Cal Contracts with the DHS, which NCQA has acknowledged in the above-described report to conform with NCQA requirements: Section 3.07, Management of Delegated Quality Improvement Activities, 3.08, Management of Delegated Credentialing Activities, and 3.09, Management of Delegated Utilization Review Activities. Sections 2.08, 2.09 and 2.10 of the Agreements conform with the Medi-Cal Plan contract and NCQA requirements that provide that the Subcontracting Plan's quality assurance, utilization review and credentialing activities are subject to the Medi-Cal Plan's standards and the oversight of the Medi-Cal Plan's Quality Assurance Committee.

In summary, this is to confirm that the parties understand and agree that the delegation provisions in the Agreements describe the Medi-Cal Plan's requirement to maintain the oversight responsibilities required by NCQA and meet the required elements of an NCQA-sufficient delegation agreement as set out in NCQA standard UM 13.1 (renumbered UM 15.1 for the NCQA Guidelines that are effective July 1, 2001).

Although the Agreements expressly provide that the Medi-Cal Plan delegated to the subcontracting party and its subcontractors both the right and duty to pharmaceutical utilization management, the following clarifies the understanding and agreement of the parties with respect to such pharmaceutical utilization management. The Subcontracting Plan and/or its subcontracting pharmacy benefits management company shall:

- Have clearly documented pharmaceutical management procedures in place, and a process for applying the procedures.
- Review such pharmaceutical management procedures at least annually and update as it determines to be necessary.
- Involve actively practicing practitioners, including pharmacists, in the development and periodic updating of its pharmaceutical management procedures.
- Provide its contracting providers its pharmaceutical management procedures and any changes that the Subcontracting Plan or subcontracting pharmacy benefits management company makes to the procedures.

- When restricting pharmacy benefits via a drug formulary, the Subcontracting Plan or subcontracting pharmacy benefits management company shall have a process to consider medical necessity exceptions for members to obtain coverage of a pharmaceutical not on the drug formulary; provided, however, the parties understand and agree that the Subcontracting Plan is not obligated to cover non-formulary medications on a medically necessary basis that are carved out from the Medi-Cal Plan's contract with the DHS, such as AIDS, HIV, Parkinson's, anti-psychotic and anti-maniac medications.
- Provide the following reports to the Medi-Cal Plan on a quarterly basis:

    1. Notification of any changes to the drug formulary.
    2. Copies of denials for pharmacy prior authorization (if any).
    3. Additions and deletions to pharmaceutical management procedures (other than drug formulary).
    4. Any changes in overall makeup of P&T Committee (e.g., different specialties represented, actual member names need not be included).

AMENDMENT OF
HEALTH NET-MOLINA LOS ANGELES COUNTY MEDI-CAL AGREEMENT

This is an amendment of the Health Services Agreement for Los Angeles County (the "Agreement") entered into by and between Molina Healthcare of California (formerly, "Molina Medical Centers") and Health Net of California, Inc. (formerly, "Foundation Health, a California Health Plan"). Subject to the terms and conditions of Restated Addendum I to the Agreement, the parties hereby amend the Agreement as follows:

1. Revised compensation arrangement for the period of October 1, 2001 through October 31, 2001. For the specified period, Health Net shall pay Molina the following monthly capitation rates for each Member assigned to Molina:

Family	$ [*]
Child	$ [*]
Disabled	$ [*]
Adult	$ [*]
Aged	$ [*]
AIDS	$ [*]

2. Revised compensation arrangement for the period of November 1, 2001 through September 30, 2002. For the specified period, Health Net shall pay Molina the following monthly capitation rates for each Member assigned to Molina:

Family	$ [*]
Child	$ [*]
Disabled	$ [*]
Adult	$ [*]
Aged	$ [*]
AIDS	$ [*]

3. Effective date of Amendment. This Amendment is effective October 1, 2001.

MOLINA HEALTHCARE OF CALIFORNIA

By: /s/

George Goldstein,
President

HEALTH NET OF CALIFORNIA, INC.

By: /s/

Dave Meadows,
Vice President
California Health Programs

CONFIDENTIAL TREATMENT HAS BEEN REQUESTED FOR PORTIONS OF THIS DOCUMENT. PORTIONS FOR WHICH CONFIDENTIAL TREATMENT IS REQUESTED ARE DENOTED BY "[*]". CONFIDENTIAL INFORMATION OMITTED HAS BEEN FILED SEPARATELY WITH THE SECURITIES AND EXCHANGE COMMISSION.

EXHIBIT 10.3

Form No. DMB 234 (Rev. 1/96)
AUTHORITY: Act 431 of 1984
COMPLETION: Required
PENALTY: Contract will not be executed unless form is filed

STATE OF MICHIGAN
DEPARTMENT OF MANAGEMENT AND BUDGET
OFFICE OF PURCHASING
P.O. BOX 30026, LANSING, MI 48909
OR
530 W. ALLEGAN, LANSING, MI 48933

CONTRACT NO. 071B1001026
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF VENDOR	
Molina Healthcare of Michigan, Inc. dba Molina Healthcare of Michigan 43097 Woodward Avenue, Suite 200 Bloomfield Hills, MI 48302	TELEPHONE Michael A. Graham (248) 454-1070
	VENDOR NUMBER/MAIL CODE (2) 38-3341599 (008)
	BUYER (517) 373-2467 /s/ Ray E. Irvine Ray E. Irvine

Contract Administrator: Rick Murdock
Comprehensive Health Care Program (CHCP) Services for Medicaid Beneficiaries in Selected Michigan Counties -- Department of Community Health

CONTRACT PERIOD:	From: October 1, 2000	To: October 1, 2002*

TERMS	SHIPMENT
N/A	N/A
F.O.B.	SHIPPED FROM
N/A	N/A

MINIMUM DELIVERY REQUIREMENTS
*Plus three (3) each possible one-year extensions

MISCELLANEOUS INFORMATION:

The terms and conditions of this Contract are those of ITB #071I0000251, this Contract Agreement and the vendor's quote dated 5-1-00, and subsequent Best And Final offer. In the event of any conflicts between the specifications, terms and conditions indicated by the State and those indicated by the vendor, those of the State take precedence.

Estimated Contract Value: The exact dollar value of this contract is unknown; the Contractor will be paid based on actual beneficiary enrollment at the rates (prices) specified in Attachment A to the Contract

THIS IS NOT AN ORDER: This Contract Agreement is awarded on the basis of our inquiry bearing the ITB No.071I0000251. A Purchase Order Form will be issued only as the requirements of the State Departments are submitted to the Office of Purchasing. Orders for delivery may be issued directly by the State Departments through the issuance of a Purchase Order Form.

All terms and conditions of the invitation to bid are made a part hereof.

FOR THE VENDOR:	FOR THE STATE:
Molina Healthcare of Michigan, Inc. dba Molina Healthcare of Michigan	/s/ David F. Ancell
Firm Name	Signature
/s/ Michael A. Graham	David F. Ancell
Authorized Agent Signature	Name
Michael A. Graham, Chief Executive Officer	State Purchasing Director
Authorized Agent (Print or Type)	Title
9/28/00	10/6/00
Date	Date

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DEFINITIONS/EXPLANATION OF TERMS

ACIP	Advisory Committee on Immunization Practices. A federal advisory committee convened by the Center for Disease Control, Public Health Service, Health & Human Services to make recommendations on the appropriate use and scheduling of vaccines and immunizations for the general public.
BALANCED BUDGET ACT	The Balanced Budget Act (BBA) of 1997 (Public law 105-33) was signed into law by President Clinton in August 1997. This legislation enacts the most significant changes to the Medicare and Medicaid Programs since their inception. Additionally, it expands the services provided through the new Child Health Insurance Program (Title XXI).
BENEFICIARY	Any person determined eligible for the Medical Assistance Program as defined below.
BLANKET PURCHASE ORDER	Alternative term for "Contract" used in the State's computer system (Michigan Automated Information Network) MAIN.
BUSINESS DAY	Monday through Friday except those days identified by the State as holidays.
CAC	Clinical Advisory Committee appointed by the DCH.
CAPITATION RATE	A fixed per person monthly rate payable to the Contractor by the DCH for provision of all Covered Services defined within this Contract. This rate shall not exceed the limits set forth in 42 CFR 447.361.
CFR	Code of Federal Regulations
CHCP	Comprehensive Health Care Program. Capitated health care services for Medicaid Beneficiaries in specified counties provided by Contractors that contract with the State.
CLEAN CLAIM	For purposes of this Contract, a Clean Claim shall be defined as in the Medicare Program unless otherwise defined by State or Federal enacted legislation. A Clean Claim is one that does not require further investigation or the development of additional information outside of the Contractor's operation before processing the claim. Clean Claims also are those that: . Pass edits and are processed electronically; . Do not require external development; . Are investigated within the Contractor's claims, medical review or payment office without the need to contact the provider, Enrollee or other outside source; Are subject to medical review but complete medical evidence is attached by the provider or forwarded simultaneously with EMC records in accordance with the Contractor's

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DEFINITIONS/EXPLANATION OF TERMS (CON'T.)

CLEAN CLAIM (CON'T.)	instructions; . Identifies the health professional or the health facility that provided treatment or service and includes a matching identifying number (provider ID number); . Identifies the patient and plan (member ID number and plan name and/or ID number); . Lists the date and place of service; . Is for covered services; . If necessary, substantiates the medical necessity and appropriateness of the care or services provided, that includes any applicable authorization number if prior authorization is required; . Includes additional documentation based upon services rendered as reasonably required by the payer; Is certified by the provider that the claim is true, accurate, prepared with the knowledge and consent of the provider, and does not contain untrue, misleading, or deceptive information, that identifies each attending, referring, or prescribing physician, dentist, or other practitioner by means of a program identification number on each claim or adjustment of a claim.
CMHSP	Community Mental Health Services Program
CONTRACT	A binding agreement between the State of Michigan and the Contractor (see also "Blanket Purchase").
CONTRACTOR	A successful Bidder who is awarded a Contract to provide services under CHCP. In this Contract, the terms Contractor, Contractor's plan, Health Plan, Qualified Health Plan, and QHP, are used interchangeably.
COVERED SERVICES	All services provided under Medicaid, as defined in Section II-H (1)-(2) that the Contractor has agreed to provide or arrange to be provided.
CSHCS	Children's Special Health Care Services.
DCH OR MDCH	The Department of Community Health or the Michigan Department of Community Health and its designated agents.
DEPARTMENT	The Department of Community Health and it designated agents.
DMB	The Department of Management and Budget.
EMERGENCY MEDICAL CARE/SERVICES	Those services necessary to treat an emergency medical condition. Emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent lay person,

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DEFINITIONS/EXPLANATION OF TERMS (CON'T.)

EMERGENCY MEDICAL CARE/SERVICES (CON'T.)	with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (i) serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part.
ENROLLEE	Any Medicaid Beneficiary that is a member of the Contractor's health plan (see Beneficiary)
ENROLLMENT CAPACITY	The number of persons that the Contractor can serve through its provider network under a Contract with the State. Enrollment Capacity is determined by a Contractor based upon its provider network and organizational capacity. The DCH will verify that the provider network is under contract and of sufficient size before accepting the enrollment capacity statement.
ENROLLMENT SERVICE	An entity contracted by the DMB to contact and educate general Medicaid and Children's Special Health Care Services Beneficiaries about managed care and to enroll, disenroll, and change enrollment(s) for these Beneficiaries.
FIA	Family Independence Agency, formerly the Department of Social Services.
FFS	Fee-for-service. A reimbursement methodology that provides a payment amount for each individual service delivered.
FQHC	Federal Qualified Health Center
HEALTH PLANS	Managed care organizations that provide or arrange for the delivery of comprehensive health care services in exchange for a fixed prepaid sum or Per Member Per Month prepaid payment without regard to the frequency, extent or kind of health care services. A Health Plan must be licensed as a Health Maintenance Organization (HMO) not later than October 1, 2000. (See also "Contractor.")
HEDIS	Health Employer Data and Information Set.
HCFA	The Health Care Financing Administration (and its designated agents) which is the federal agency within the United States Department of Health and Human Services responsible for administration of the Medicaid and Medicare programs.
HMO	An entity defined in Michigan Compiled Laws (MCL 333.21005(2)) that has received and maintains a state license to operate as an HMO.

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DEFINITIONS/EXPLANATION OF TERMS (CON'T.)

LONG TERM CARE FACILITY	Any facility licensed and certified by the Michigan Department of Community Health, in accordance with 1978 PA 368, as amended, to provide inpatient nursing care services.
MECICAID/MEDICAL ASSISTANCE PROGRAM	A federal/state program authorized by the Title XIX of the Social Security Act, as amended, 42 U.S.C. 1396 et seq.; and section 105 of 1939 PA 280, as amended, MCL 400.105; which provides federal matching funds for a Medical Assistance Program. Specified medical and financial eligibility requirements must be met.
MSA	Medical Services Administration, the agency within the Department of Community Health responsible for the administration of the Medicaid Program.
PCP	Primary Care Provider. Those providers within the Health Plans who are designated as responsible for providing or arranging health care for specified Enrollees of the Contractor. A PCP may be any of the following: family practice physician, general practice physician, internal medicine physician, OB/GYN specialist, pediatric physician when appropriate for an Enrollee, other physician specialists when appropriate for an Enrollee's health condition, nurse practitioner, and physician assistants.
PMPM	Per Member Per Month.
PROVIDER	Provider means a health facility or a person licensed, certified, or registered under parts 61 to 65 or 161 to 182 of Michigan's Public Health code, 1978 PA 368, as amended, MCL 333.6101- 333.6523 and MCL 333.16101-333.18237.
PURCHASING OFFICE	The Office of Purchasing within the Department of Management and Budget that is the sole point of contact throughout the procurement process.
QIC	Quality Improvement Committee appointed by the Contractor.
QHP	A Qualified Health Plan awarded a Contract to provide services under CHCP. (See also "Contractor").
RFP	Request for Proposal. Interchangeable with ITB, (Invitation to Bid). A procurement document that describes the services required, and instructs prospective Bidders how to prepare a response.

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DEFINITIONS/EXPLANATION OF TERMS (CON'T.)

RURAL	Rural is defined as any county not included in a standard metropolitan area (SMA).
SUCCESSFUL BIDDER	The Bidder (Contractor) awarded a Contract as a result of a proposal submitted in response to the ITB.
STATE	The State of Michigan.
STATE PURCHASING DIRECTOR	The Director of the Office of Purchasing within the Department of Management and Budget. Also referred to as Director of Purchasing.
VFC	Vaccines for Children program. A federal program which makes vaccine available free in immunize children age 18 and under who are Medicaid eligible, who have no health insurance, who are native Americans or Alaskans, or who have health insurance but not for immunizations and receive their immunization at a FQHC.
WELL CHILD VISITS/EPSDT	Early and periodic screening, diagnosis, and treatment program. A child health program of prevention and treatment intended to ensure availability and accessibility of primary, preventive, and other necessary health care resources and to help Medicaid children and their families to effectively use these resources.

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SECTION I
CONTRACTUAL SERVICES TERMS AND CONDITIONS

I-A PURPOSE

The State of Michigan, by the Department of Management and Budget (DMB), Office of Purchasing, hereby enters into a Contract with the Contractor identified in Section III-A for the Michigan Department of Community Health (DCH).

The purpose of this Contract is to obtain the services of the Contractor to provide Comprehensive Health Care Program (CHCP) Services for Medicaid beneficiaries (Beneficiaries) in the service area as described in Attachment B to this Contract. This is a unit price (Per Member Per Month [PMPM] Capitated Rate) Contract, see Attachment A. The term of the Contract shall be effective October 1, 2000 and continue to October 1, 2002. The Contract may be extended for no more than three(3) one year extensions after September 30, 2002.

I-B ISSUING OFFICE

This Contract is issued by DMB, Office of Purchasing (Office of Purchasing), for and on the behalf of DCH. Where actions are a combination of those of the Office of Purchasing and DCH, the authority will be known as the State.

The Office of Purchasing is the sole point of contact in the State with regard to all procurement and contractual matters relating to the services describe herein.. The Office of Purchasing is the only office authorized to change, modify, amend, clarify, or otherwise alter the prices, specifications, terms, and conditions of this Contract. The OFFICE OF PURCHASING will remain the SOLE POINT OF CONTACT until such time as the Director of Purchasing shall direct otherwise in writing. See Paragraph I-C below. All communications with the DMB must be addressed to:

Ray Irvine
Office of Purchasing
Department of Management & Budget
P.O. Box 30026
Lansing, MI 48909

I-C CONTRACT ADMINISTRATOR

Upon receipt by the Office of Purchasing of the properly executed Contract, it is anticipated that the Director of Purchasing will direct that the person named below be authorized to administer the Contract on a day-to-day basis during the term of the Contract. However, administration of this Contract implies no authority to change, modify, clarify, amend, or otherwise alter the prices, terms, conditions, and specifications of the Contract. That authority is retained by the Office of Purchasing. The Contract Administrator for this project is:

Richard B. Murdock, Director
Comprehensive Health Plan Division
Medical Services Administration
Department of Community Health
P.O. Box 30479
Lansing, Michigan 48909

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I-D TERM OF CONTRACT

The term of this Contract shall be from October 1, 2000 through September 30, 2002. The Contract may be extended for no more than three (3) one year extensions after September 30, 2002. The State's fiscal year is October 1st through September 30th. Payments in any given fiscal year are contingent upon and subject to enactment of legislative appropriations.

Because Beneficiaries must have a choice among Contractors, the State cannot guarantee an exact number of Enrollees to any Contractor.

1-E PRICE

Prices shall be held firm through September 30, 2001. Prices offered by the Contractor in the response to the RFP for the period October 1, 2001 through October 1, 2002 are subject to written acceptance by the Director of Purchasing. Price adjustments for this second year period of the Contract and for any Contract extension thereafter may be proposed by the State or the Contractor. Price adjustments proposed by the Contractor must be submitted in writing to the Director of Purchasing no later than June 15th of each contract year. Price adjustments proposed by the State will be submitted to the Contractor in no later than June 15th of each contract year.

Any changes requested by either party are subject to negotiation and written acceptance by the State Purchasing Director before becoming effective. In the event the State and the Contractor cannot agree to changes by August 31st of each contract year, the Contract may be canceled pursuant to Section I-O (6) CANCELLATION. The exact dollar value of this Contract is unknown; the Contractor will be paid based on actual Beneficiary enrollment at the rates (prices) specified in Attachment "A" (Awarded Prices) of the Contract.

I-F COST LIABILITY

The State assumes no responsibility or liability for costs incurred by the Contractor prior to the signing of this Contract by all parties. Total liability of the State is limited to the terms and conditions of this Contract.

I-G CONTRACTOR RESPONSIBILITIES

The Contractor will be required to assume responsibility for all contractual activities relative to this Contract whether or not that Contractor performs them. Further, the State will consider the Contractor to be the sole point of contact with regard to contractual matters, including payment of any and all charges resulting from the Contract. Although it is anticipated that the Contractor will perform the major portion of the duties as requested, subcontracting by the Contractor for performance of any of the functions requires prior notice to the State. The Contractor must identify all subcontractors, including firm name and address, contact person, complete description of work to be subcontracted, and descriptive information concerning subcontractor's organizational abilities. The Contractor must also outline the contractual relationship between the Contractor and each subcontractor. The State reserves the right to approve subcontractors for administrative functions for this project and to require the

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Contractor to replace subcontractors found to be unacceptable. The Contractor is totally responsible for adherence by the subcontractor to all provisions of the Contract.

A subcontractor is any person or entity that performs a required, ongoing function of the Contractor under this Contract. A health care provider included in the network of the Contractor is not considered a subcontractor for purposes of this Contract unless otherwise specifically noted in this Contract. Contracts for one-time only functions or service contracts, such as maintenance or insurance protection, are not intended to be covered by this section.

Although Contractors may enter into subcontracts, all communications shall take place between the Contractor and the State directly; therefore, all communication by subcontractors must be with the Contractor only, not with the State.

If a Contractor elects to use a subcontractor not specified in the Contractor's response, the State must be provided with a written request at least 21 days prior to the use of such subcontractor. Use of a subcontractor not approved by the State may be cause for termination of the Contract.

In accordance with 42 CFR 434.6(b), all subcontracts entered into by the Contractor must be in writing and fulfill the requirements of 42 CFR 434.6(a) that are appropriate to the service or activity delegated under the subcontract. All subcontracts must be in compliance with all State of Michigan statutes and will be subject to the provisions thereof. All subcontracts must fulfill the requirements of this Contract that are appropriate to the services or activities delegated under the subcontract. For each portion of the proposed services to be arranged for and administered by a subcontractor, the technical proposal must include: (1) the identification of the functions to be performed by the subcontractor, and (2) the subcontractor's related qualifications and experience. All employment agreements, provider contracts, or other arrangements by which the Contractor intends to deliver services required under this Contract, whether or not characterized as a subcontract, shall be subject to review and approval by the State and must meet all other requirements of this paragraph appropriate to the service or activity delegated under the agreement.

The Contractor shall furnish information to the State as to the amount of the subcontract, the qualifications of the subcontractor for guaranteeing performance, and any other data that may be required by the State. All subcontracts held by the Contractor shall be made available on request for inspection and examination by appropriate State officials, and such relationships must meet with the approval of the State.

The Contractor shall furnish information to the State necessary to administer all requirements of the Contract. The State shall give Contractors at least 30 days notice before requiring new information.

I-H NEWS RELEASES

News releases pertaining to this document or the services, study, data, or project to which it relates will not be made without prior written State approval, and then only in accordance with the explicit written instructions from the State. No information or data related to this Contract is to be released without prior approval of the designated State personnel.

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I-I DISCLOSURE

All information in this Contract is subject to the provisions of the Freedom of Information Act, 1976 PA 442, as amended, MCL 15.231, et seq.

I-J CONTRACT INVOICING AND PAYMENT

This Contract reflects a fixed reimbursement mechanism and the specific payment schedule for this Contract will be monthly. The services will be under a fixed price per covered member multiplied by the actual member count assigned to the Contractor in the month for which payment is made. DCH will generate reports to the Contractor prior to month's end identifying expected enrollment for the following service month. At the beginning of the service month, DCH will automatically generate invoices based on actual member enrollment. The Contractor will receive one lump-sum payment approximately at mid-service month. A process will be in place to ensure timely payments and to identify Enrollees that the Contractor was responsible for during the month but for which no payment was received in the service month (e.g., newborns).

The application of Contract remedies and performance bonus payments as described in Section II of this Contract will affect the lump sum payment. Payments in any given fiscal year are contingent upon and subject to enactment of legislative appropriations.

I-K ACCOUNTING RECORDS

The Contractor will be required to maintain all pertinent financial and accounting records and evidence pertaining to the Contract in accordance with generally accepted accounting principles and other procedures specified by the State of Michigan. Financial and accounting records shall be made available, upon request, to the Health Care Financing Administration (HCFA), the State of Michigan, its designees, the Department of Attorney General, or the Office of Auditor General at any time during the Contract period and any extension thereof, and for six (6) years from expiration date and final payment on the Contract or extension thereof.

I-L INDEMNIFICATION

1. General Indemnification

The Contractor shall indemnify, defend and hold harmless the State, its departments, divisions, agencies, sections, commissions, officers, employees and agents, from and against all losses, liabilities, penalties, fines, damages and claims (including taxes), and all related costs and expenses (including reasonable attorneys' fees and disbursements and costs of investigation, litigation, settlement, judgments, interest and penalties), arising from or in connection with any of the following:

(a) any claim, demand, action, citation or legal proceeding against the State, its employees and agents arising out of or resulting from (1) the products and services provided or (2) performance of the work, duties, responsibilities, actions or omissions of the Contractor or any of its subcontractors under this Contract;

(b) any claim, demand, action, citation or legal proceeding against the State, its employees and agents arising out of or resulting from a breach by the Contractor of any representation or warranty made by the Contractor in the Contract;

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(c) any claim, demand, action, citation or legal proceeding against the State, its employees and agents arising out of or related to occurrences that the Contractor is required to insure against as provided for in this Contract;

(d) any claim, demand, action, citation or legal proceeding against the State, its employees and agents arising out of or resulting from the death or bodily injury of any person, or the damage, loss or destruction of any real or tangible personal property, in connection with the performance of services by the Contractor, by any of its subcontractors, by anyone directly or indirectly employed by any of them, or by anyone for whose acts any of them may be liable;

(e) any claim, demand, action, citation or legal proceeding against the State, its employees and agents which results from an act or omission of the Contractor or any of its subcontractors in its or their capacity as an employer of a person.

2. Patent/Copyright Infringement Indemnification

The Contractor shall indemnify, defend and hold harmless the State, its employees and agents from and against all losses, liabilities, damages (including taxes), and all related costs and expenses (including reasonable attorney's fees and disbursements and costs of investigation, litigation, settlement, judgments, interest and penalties) incurred in connection with any action or proceeding threatened or brought against the State to the extent that such action or proceeding is based on a claim that any piece of equipment, software, commodity or service supplied by the Contractor or its subcontractors, or the operation of such equipment, software, commodity or service, or the use or reproduction of any documentation provided with such equipment, software, commodity or service infringes any United States of America or foreign patent, copyright, trade secret or other proprietary right of any person or entity, which right is enforceable under the laws of the United States of America. In addition, should the equipment, software, commodity, or service, or the operation thereof, become or in the Contractor's opinion be likely to become the subject of a claim of infringement, the Contractor shall at the Contractor's sole expense (i) procure for the State the right to continue using the equipment, software, commodity or service or, if such option is not reasonably available to the Contractor, (ii) replace or modify the same with equipment, software, commodity or service of equivalent function and performance so that it becomes non-infringing, or, if such option is not reasonably available to the Contractor, (iii) accept its return by the State with appropriate credits to the State against the Contractor's charges and reimburse the State for any losses or costs incurred as a consequence of the State ceasing its use and returning it.

3. Indemnification Obligation Not Limited

In any and all claims against the State of Michigan, or any of its agents or employees, by any employee of the Contractor or any of its subcontractors, the indemnification obligation under the Contract shall not be limited in any way by the amount or type of damages, compensation or benefits payable by or for the Contractor or any of its subcontractors under worker's disability compensation acts, disability benefits acts, or other employee benefits acts. This indemnification clause is intended to be comprehensive. Any overlap in subclauses, or the fact that greater specificity is provided as to some categories of risk, is not intended to limit the scope of indemnification under any other subclause.

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4. Continuation of Indemnification Obligation

The duty to indemnify will continue in full force and effect notwithstanding the expiration or early termination of the Contract with respect to any claims based on facts or conditions that occurred prior to termination.

5. Exclusion

The Contractor is not required to indemnify the State of Michigan for services provided by health care providers mandated under federal statute or State policy, unless the health care provider is a voluntary contractual member of the Contractor's provider network. Local agreements with Community Mental Health Services program (CMHSP) do not constitute network provider contracts.

I-M CONTRACTOR'S LIABILITY INSURANCE

The Contractor shall purchase and maintain such insurance as will protect it from claims set forth below, which may arise out of or result from the Contractor's operations under the Contract whether such operations are by it or by any subcontractor or by anyone directly or indirectly employed by any of them, or by anyone for whose acts any of them may be liable:

1) Claims under workers' disability compensation, disability benefit and other similar employee benefit act. A non-resident Contractor shall have insurance for benefits payable under Michigan's Workers' Disability Compensation Law for any employee resident of and hired in Michigan; and as respects any other employee protected by workers' disability compensation laws of any other state the Contractor shall have insurance or participate in a mandatory State fund to cover the benefits payable to any such employee.

   In the event any work is subcontracted, the Contractor shall require the subcontractor similarly to provide workers' compensation insurance for all the subcontractor's employees working in the State, unless those are covered by the workers' compensation protection afforded by the Contractor. Any subcontract executed with a firm not having the requisite workers' compensation coverage will be considered void by the State.

2) Claims for damages because of bodily injury, occupational sickness or disease, or death of its employees.

3) Claims for damages because of bodily injury, sickness or disease, or death of any person other than its employees, subject to limits of liability of not less than $1,000,000.00 each occurrence and, when applicable, $2,000,000.00 annual aggregate for non-automobile hazards and as required by law for automobile hazards.

4) Claims for damages because of injury to or destruction of tangible property, including loss of use resulting therefrom, subject to a limit of liability of not less than $50,000.00 each occurrence for non-automobile hazards and as required by law for automobile hazards.

5) Insurance for subparagraphs (3) and (4) non-automobile hazards on a combined single limit of liability basis shall not be less than $1,000,000.00 each occurrence and when applicable, $2,000,000.00 annual aggregate.

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6) Director's and Officer's Errors and Omissions coverage that includes coverage of the Contractor's peer review and care management activities and has limits of at least $1,000,000.00 per occurrence and $3,000,000.00 aggregate.

7) The Contractor shall also require that each of its subcontractors maintain insurance coverage as specified above, except for subparagraph (6), or have the subcontractors provide coverage for each subcontractor's liability and employees. The Contractor must provide proof, upon request of the DCH, of its Provider's medical professional liability insurance in amounts consistent with the community accepted standards for similar professionals. The provision of this clause shall not be deemed to limit the liability or responsibility of the Contractor or any of its subcontractors herein.

8) The insurance shall be written for not less than any limits of liability herein specified or required by law, whichever is greater, and shall include contractual liability insurance as applicable to the Contractor's obligations under the Indemnification clause of the Contract.

9) BEFORE STARTING WORK THE CONTRACTOR'S INSURANCE AGENCY MUST FURNISH TO THE DIRECTOR OF THE OFFICE OF PURCHASING, ORIGINAL CERTIFICATE(S) OF INSURANCE VERIFYING THAT THE REQUIRED LIABILITY COVERAGE IS IN EFFECT FOR THE AMOUNTS SPECIFIED IN THE CONTRACT. THE CONTRACT NUMBER MUST BE SHOWN ON THE CERTIFICATE OF INSURANCE TO ENSURE CORRECT FILING. The Contractor must immediately notify the State of any changes in type, amount, or duration of insurance coverage. These certificates shall contain a provision to the effect that the policy will not be canceled until at least fifteen days prior written notice has been given to the State. The written notice will have the Contract number and must be received by the Director of Purchasing.

I-N LITIGATION

The State, its departments, and its agents shall not be responsible for representing or defending the Contractor, Contractor's personnel, or any other employee, agent or subcontractor of the Contractor, named as a defendant in any lawsuit or in connection with any tort claim.

The State and the Contractor agree to make all reasonable efforts to cooperate with each other in the defense of any litigation brought by any person or persons not a party to the Contract.

The Contractor shall submit annual litigation reports in a format established by DCH, providing the following detail for all civil litigation that the Contractor, subcontractor, or the Contractor's insurers or insurance agents are parties to:

Case name and docket number
Name of plaintiff(s) and defendant(s)
Names and addresses of all counsel appearing
Nature of the claim
Status of the case.

The provisions of this section shall survive the expiration or termination of the Contract.

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I-O CANCELLATION

1) The State may cancel the Contract for default of the Contractor. Default is defined as the failure of the Contractor to fulfill the obligations of the proposal or Contract. In case of default by the Contractor, the State may immediately cancel the Contract without further liability to the State, its departments, agencies, and employees, and procure the articles or services from other sources, and hold the Contractor responsible for all costs occasioned thereby.

2) The State may cancel the Contract in the event the State no longer needs the services or products specified in the Contract, or in the event program changes, changes in laws, rules or regulations occur. The State may cancel the Contract without further liability to the State, its departments, divisions, agencies, sections, commissions, officers, agents and employees by giving the Contractor written notice of such cancellation 30 days prior to the date of cancellation.

3) The State may cancel the Contract for lack of funding. The Contractor acknowledges that the term of this Contract extends for several fiscal years and that continuation of this Contract is subject to appropriation of funds for this project. If funds to enable the State to effect continued payment under this Contract are not appropriated or otherwise made available, the State shall have the right to terminate this Contract without penalty at the end of the last period for which funds have been appropriated or otherwise made available by giving written notice of termination to the Contractor. The State shall give the Contractor written notice of such non-appropriation within 30 days after it receives notice of such non-appropriation.

4) The State may immediately cancel the Contract without further liability to the State, its departments, divisions, agencies, sections, commissions, officers, agents and employees if the Contractor, an officer of the Contractor, or an owner of a 25% or greater share of the Contractor, is convicted of a criminal offense incident to the application for or performance of a State, public, or private contact or subcontract; or convicted of a criminal offense including but not limited to any of the following: embezzlement, theft, forgery, bribery, falsification or destruction of records, receiving stolen property, attempting to influence a public employee to breach the ethical conduct standards for State of Michigan employees; convicted under state or federal antitrust statutes; or convicted of any other criminal offense, which, in the sole discretion of the State, reflects poorly on the Contractor's business integrity.

5) The State may immediately cancel the Contract in whole or in part by giving notice of termination to the Contractor if any final administrative or judicial decision or adjudication disapproves a previously approved request for purchase of personal services pursuant to Constitution 1963, Article 11, Section 5, and Civil Service Rule 4-6.

6) The State may, with 30 days written notice to the Contractor, cancel the Contract in the event prices proposed for Contract modification/extension are unacceptable to the State. (See Sections I-E, Price, and I-T, Modification of Contract).

7) Either the State or the Contractor may, upon 90 days written notice, cancel the contract for the convenience of either party.

In the event that a Contract is canceled, the Contractor will cooperate with the State to implement a transition plan for Enrollees. The Contractor will be paid for Covered Services provided during the transition period in accordance with the Capitation Rates in effect between the Contractor and the State at the time of cancellation. Contractors will be provided due process before the termination of any Contract.

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I-P ASSIGNMENT

The Contractor shall not have the right to assign or delegate any of its duties or obligations under this Contract to any other party (whether by operation of law or otherwise), without the prior written consent of the State Purchasing Director. To obtain consent for assignment of this Contract to another party, documentation must be provided to the State Purchasing Director to demonstrate that the proposed assignee meets all of the requirements for a Contractor under this Contract. Any purported assignment in violation of this Section shall be null and void. Further, the Contractor may not assign the right to receive money due under the Contract without consent of the Director of Purchasing.

I-Q DELEGATION

The Contractor shall not delegate any duties or obligations under this Contract to a subcontractor other than a subcontractor named in the bid unless the State Purchasing Director has given written consent to the delegation.

I-R CONFIDENTIALITY

The use or disclosure of information regarding Enrollees obtained in connection with the performance of this Contract shall be restricted to purposes directly related to the administration of services required under the Contract.

I-S NON-DISCRIMINATION CLAUSE

The Contractor shall comply with the Elliott-Larsen Civil Rights Act, 1976 PA 453, as amended, MCL 37.2101 et seq., the Persons with Disabilities Civil Rights Act, 1976 PA 220, as amended, MCL 37.1101 et seq., and all other federal, state and local fair employment practices and equal opportunity laws and covenants that it shall not discriminate against any employee or applicant for employment, to be employed in the performance of this Contract, with respect to his or her hire, tenure, terms, conditions, or privileges of employment, or any matter directly or indirectly related to employment, because of his or her race, religion, color, national origin, age, sex, height, weight, marital status, or physical or mental disability that is unrelated to the individual's ability to perform the duties of a particular job or position. The Contractor agrees to include in every subcontract entered into for the performance of this Contract this covenant not to discriminate in employment. A breach of this covenant is a material breach of this Contract.

I-T MODIFICATION OF CONTRACT

The Director of Purchasing reserves the right to modify Covered Services required under this Contract during the course of this Contract. Such modification may include adding or deleting tasks that this service shall encompass and/or any other modifications deemed necessary. Any changes in pricing proposed by the Contractor resulting from the requested changes are subject to acceptance by the State. Changes may be increases or decreases. Contract changes will not be necessary in order for the Contractor to keep current with changes in the delivery of Covered Services that may result from new technology or new drugs.

IN THE EVENT PRICES SUBMITTED AS THE RESULT OF A MODIFICATION OF COVERED SERVICE ARE NOT ACCEPTABLE TO THE STATE, THE CONTRACT MAY BE TERMINATED AND THE CONTRACT MAY BE SUBJECT TO COMPETITIVE

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BIDDING AND AWARD BASED UPON THE NEW MODIFIED COVERED SERVICES IF ADEQUATE CAPACITY IS NOT READILY AVAILABLE TO SERVE BENEFICIARIES IN THE AFFECTED SERVICE AREA THROUGH EXISTING CONTRACTS WITH OTHER CONTRACTORS.

I-U ACCEPTANCE OF PROPOSAL CONTENT

The contents of the RFP and the Contractor's proposal resulting in this Contract are contractual obligations.

I-V RIGHT TO NEGOTIATE EXPANSION

The State reserves the right to negotiate expansion of the services outlined within this Contract to accommodate the related service needs of additional selected State agencies, or of additional entities within DCH.

Such expansion shall be limited to those situations approved and negotiated by the Office of Purchasing at the request of DCH or another State agency. The Contractor shall be obliged to expeditiously evaluate and respond to specified needs submitted by the Office of Purchasing with a proposal outlining requested services and pricing. All pricing for expanded services shall be shown to be consistent with the cost elements and/or unit pricing of the original Contract.

In the event that a Contract expansion proposal is accepted by the State, the Office of Purchasing shall issue a Contract change notice to the Contract as notice to the Contractor to provide the work specified. Compensation is not allowed the Contractor until such time as a Contract change notice is issued.

I-W MODIFICATIONS, CONSENTS AND APPROVALS

This Contract will not be modified, amended, extended, or augmented, except by a writing executed by the parties hereto, and any breach or default by a party shall not be waived or released other than in writing signed by the other party.

I-X ENTIRE AGREEMENT AND ORDER OF PRECEDENCE

The following documents constitute the complete and exclusive statement of the agreement between the parties as it relates to this transaction. In the event of any conflict among the documents making up the Contract, the following order of precedence shall apply (in descending order of precedence):

A. This Contract and any Addenda thereto
B. State's RFP and any Addenda thereto
C. Contractor's proposal to the State's RFP and Addenda
D. Policy manuals of the Medical Assistance Program and subsequent publications

In the event of any conflict over the interpretation of the specifications, terms, and conditions indicated by the State and those indicated by the Contractor, those of the State take precedence.

This Contract supersedes all proposals or other prior agreements, oral or written, and all other communications between the parties.

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I-Y NO WAIVER OF DEFAULT

The failure of the State to insist upon strict adherence to any term of this Contract shall not be considered a waiver or deprive the State of the right thereafter to insist upon strict adherence to that term, or any other term, of the Contract.

I-Z SEVERABILITY

Each provision of this Contract shall be deemed to be severable from all other provisions of the Contract and, if one or more of the provisions shall be declared invalid, the remaining provisions of the Contract shall remain in full force and effect.

I-AA DISCLAIMER

All statistical and fiscal information contained within the Contract and its attachments, and any amendments and modifications thereto, reflect the best and most accurate information available to DCH at the time of drafting. No inaccuracies in such data shall constitute a basis for legal recovery of damages, either real or punitive.

Captions and headings used in this Contract are for information and organization purposes. Captions and headings, including inaccurate references, do not, in any way, define or limit the requirements or terms and conditions of this Contract.

I-BB RELATIONSHIP OF THE PARTIES (INDEPENDENT CONTRACTOR)

The relationship between the State and the Contractor is that of client and independent contractor. No agent, employee, or servant of the Contractor or any of its subcontractors shall be deemed to be an employee, agent or servant of the State for any reason. The Contractor will be solely and entirely responsible for its acts and the acts of its agents, employees, servants, and subcontractors during the performance of a contract resulting from this Contract.

I-CC NOTICES

Any notice given to a party under this Contract must be written and shall be deemed effective, if addressed to such party at the address indicated in sections I-B, I-C and III-A of this Contract upon (i) delivery, if hand delivered; (ii) receipt of a confirmed transmission by telefacsimile if a copy of the notice is sent by another means specified in this Section; (iii) the third (3rd) Business Day after being sent by U.S. mail, postage pre-paid, return receipt requested; or (iv) the next Business Day after being sent by a nationally recognized overnight express courier with a reliable tracking system.

Either party may change its address where notices are to be sent by giving written notice in accordance with this Section.

I-DD UNFAIR LABOR PRACTICES

Pursuant to 1980 PA 278, as amended, MCL 423.321 et seq., the State shall not award a contract or subcontract to an employer or any subcontractor, manufacturer or supplier of the employer, whose name appears in the current register compiled by the Michigan Department of Consumer and Industry Services. The State may void any contract if, subsequent to award of the Contract, the name of the Contractor as an employer, or the name of the subcontractor, manufacturer of supplier of the contractor appears in the register.

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I-EE SURVIVOR

Any provisions of the Contract that impose continuing obligations on the parties including, but not limited to, the Contractor's indemnity and other obligations, shall survive the expiration or cancellation of this Contract for any reason.

I-FF GOVERNING LAW

This Contract shall in all respects be governed by, and construed in accordance with, the laws of the State of Michigan.

I-GG YEAR 2000 SOFTWARE COMPLIANCE

The Contractor warrants that all software which the Contractor either sells or licenses to the State of Michigan and used by the State prior to, during or after the calendar year 2000, includes or shall include, at no added cost to the State, design and performance so the State shall not experience software abnormality and/or the generation of incorrect results from the software, due to date oriented processing, in the operation of the business of the State of Michigan.

The software design, to insure year 2000 compatibility, shall include, but is not limited to: data structures (databases, data files, etc.) that provide 4-digit date century; stored data that contain date century recognition, including, but not limited to, data stores in databases and hardware device internal system dates; calculations and program logic (e.g., sort algorithms, calendar generation, event recognition, and all processing actions that use or produce date values) that accommodates same century and multi-century formulas and date values; interfaces that supply data to and receive data from other systems or organizations that prevent non-compliant dates and data from entering any State system; user interfaces (i.e., screens, reports, etc.) that accurately show 4 digit years; and assurance that the year 2000 shall be correctly treated as a leap year within all calculation and calendar logic.

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SECTION II
WORK STATEMENT

II-A BACKGROUND/PROBLEM STATEMENT

1. Value Purchasing

The creation of DCH through Executive Order 1996-1 brought together policy, programs and resources to enable the State to become a more effective purchaser of health care services for the Medicaid population. As the single State agency responsible for health policy and purchasing of health care services using State appropriated and federal matching funds, DCH intends to get better value while ensuring quality and access. DCH will focus on "value purchasing". Value purchasing involves aligning financing incentives to stimulate appropriate changes in the health delivery system that will:

- bring organization and accountability for the full range of benefits,
- provide greater flexibility in the range of services;
- improve access to and quality of care;
- achieve greater cost efficiency; and
- link performance of Contractors to improvements in the health status of the community.

2. Managed Care Direction

Under the Comprehensive Health Care Program (CHCP), the State selectively contracts with Contractors who will accept financial risk for managing comprehensive care through a performance contract. The managed care direction is the health care purchasing direction for Michigan's future. Change in health care delivery systems is happening at the national and state levels. Michigan will proactively work to shape the health care marketplace as a purchaser of services. The focus will be on quality of care, accessibility, and cost-effectiveness.

It is critical that Michigan act now to bring the rate of growth in Medicaid more in line with the forecasted rate of growth in State revenues. Since 1990, State revenues have grown by about 3% per year. The growth of the Medicaid budget must be slowed but, at the same time, access to quality health care for the Medicaid population must be ensured.

There are three basic ways to slow down cost growth: restrict eligibility, reduce benefits, or stimulate more efficiency in the health delivery system through managed care. DCH has chosen not to make program cuts, but rather to use the efficiency approach because other important health care goals can be achieved at the same time.

There are two categories of specialized services that are available outside of the CHCP. These are behavioral health services and services for persons with developmental disabilities. These specialized services are clearly defined as beyond the scope of benefits that are included in the CHCP. Any Contractor contracting with the State as a capitated managed care provider will be responsible for coordinating access to these specialized services with those providers designated by the State to provide them. The criteria for contracted Qualified Health Plans (QHPs) include the implementation of local agreements with the behavioral health and developmental disability providers who are under

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contract with DCH. Model agreements between Contractors and behavioral health and developmental disability providers are included in the appendix to this Contract.

II-B OBJECTIVES

1. Objectives

The Contract objectives of the State are:

- the assurance of access to primary and preventive care;
- the coordination for all necessary health care services;
- the provision of medical care that is of high quality, provides continuity and is appropriate for the individual; and
- the delivery of health care in a manner that makes costs more predictable for the Medicaid population.

2. Objectives for Special Needs

When providing services under the CHCP, the Contractor must take into consideration the requirements of the Medicaid program and how to best serve the Medicaid population in the CHCP. As an objective, the Contractor must also stress the collaborative effort of both the State and the private sector to operate a managed care system that meets the special needs of these Enrollees.

It is recognized that special needs will vary by individual and by county or region. Contractors must have an underlying organizational capacity to address the special needs of their Enrollees, such as: responding to requests for assignment of specialists as Primary Care Providers (PCP), assisting in coordinating with other support services, and generally responding and anticipating needs of Enrollees with special needs. Under their Covered Service responsibilities, Contractors are expected to provide early prevention and intervention services for recipients with special needs, as well as all other recipients.

As an example, while support services for persons with developmental disabilities may be outside of the direct service responsibility of the Contractor, the Contractor does have responsibility to assist in coordinating arrangements to receive necessary support services. This coordination must be consistent with the person-centered planning principles established within the revised Michigan's Mental Health Code.

Another example would be for Enrollees who have chronic illnesses such as diabetes or end-stage renal disease. In these instances, the PCP assignment may be more appropriately located with a specialist within the Contractor's network. When a Contractor designates a physician specialist as the PCP, that PCP will be responsible for coordinating all continuing medical care for the assigned Enrollee.

3. Objectives for Contractor Accountability

Contractor accountability must be established in order to ensure that the State's objectives for managed care and goal for immunizations are met and the objectives for special populations are addressed. Contractors contracting with the State will be held accountable for:

- Ensuring that all Covered Services are available and accessible to Enrollees with reasonable promptness and in a manner which ensures continuity.

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Medically necessary services shall be available and accessible 24 hours a day and 7 days a week.

- Delivering health care services in a manner that focuses on health promotion and disease prevention and features disease management strategies.
- Demonstrating the Contractor's capacity to adequately serve the Contractor's expected enrollment of Enrollees.
- Providing access to appropriate providers, including qualified specialists for all medically necessary services including those specialists described under model agreements for behavioral health and developmental disabilities.
- Providing assurances that it will not deny enrollment to, expel, or refuse to re- enroll any individual because of the individual's health status or need for services, and that it will notify all eligible persons of such assurances at the time of enrollment.
- Paying providers in a timely manner for all Covered Services.
- Establishing an ongoing internal quality improvement and utilization review program.
- Providing procedures to ensure program integrity through the detection and elimination of fraud and abuse and cooperate with DCH and the Department of Attorney General as necessary.
- Reporting encounter data and aggregate data including data on inpatient and outpatient hospital care, physician visits, pharmaceutical services, and other services specified by the Department.
- Providing procedures for hearing and timely resolving grievances between the Contractor and Enrollees.
- Providing for outreach and care coordination to Enrollees to assist them in using their health care resources appropriately.
- Collaborating, through local agreements, with specialized behavioral and developmental disability services contractors on services provided by them to the Contractor's Enrollees.
- Providing assurances for the Contractor's solvency and guaranteeing that Enrollees and the State will not be liable for debts of the Contractor.
- Meeting all standards and requirements contained in this Contract, and complying with all applicable federal and state laws, administrative rules, and policies promulgated by DCH.
- Cooperating with the State and/or HCFA in all matters related to fulfilling Contract requirements and obligations.

II-C SPECIFICATIONS

The following sections provide an explanation of the specifications and expectations that the Contractor must meet and the services that must be provided under the Contract. The Contractor is not, however, constrained from supplementing this with additional services or elements deemed necessary to fulfill the intent of the CHCP.

II-D TARGETED GEOGRAPHICAL AREA FOR IMPLEMENTATION OF THE CHCP

1. Regions

The State will divide the delivery of Covered Services into ten regions.

Contractor's plans for Region 1 and 10 must be tailored to each county in terms of the provider network, Enrollment Capacity and Capitation Rates. Region 1 (Wayne County) and Region 10 (Oakland County) may have partial county service areas.

Contractor's plans for Regions 2 through 9 must establish:

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(a) a network of providers that guarantees access to required services for the entire region; or

(b) a network of providers that guarantees access to required services for a significant portion of the region.

Under alternative (b) the Contract must specifically identify the contiguous portion of the region that will be served along (entire counties) with a description of the available provider network.

The counties included in the specific regions are as follows:

Region 1: Wayne

Region 2: Hillsdale, Jackson, Lenawee, Livingston, Monroe, and Washtenaw

Region 3: Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, Van Buren

Region 4: Allegan, Antrim, Benzie, Charlevoix, Cheboygan, Emmet, Grand Traverse, Ionia, Kalkaska, Kent, Lake, Leelanau Manistee, Mason, Mecosta, Missaukee, Montcalm, Muskegon, Newaygo, Oceana, Osceola, Ottawa, and Wexford

Region 5: Clinton, Eaton, Ingham

Region 6: Genesee, Lapeer, Shiawassee

Region 7: Alcona, Alpena, Arenac, Bay, Clare, Crawford, Gladwin, Gratiot, Huron, Iosco, Isabella, Midland, Montmorency, Ogemaw, Oscoda, Otsego, Presque Isle, Roscommon, Saginaw, Sanilac, Tuscola

Region 8: Alger, Baraga, Chippewa, Delta, Dickinson, Gogebic Houghton, Iron, Keweenaw, Luce, Mackinac, Marquette, Menominee, Ontonagon, Schoolcraft

Region 9: Macomb and St. Clair

Region 10: Oakland

2. Multiple Region Service Areas

Although Contractors may propose to contract for services in more than one of the above described regions, the Contractor agrees to tailor its services to each individual region in terms of the provider network, Enrollment Capacity, and Capitation Rates. DCH may determine Contractors to be qualified in one region but not in another.

Contractor may request service area expansion at any time during the term of the Contract using the provider profile information form contained in Appendix D of the Contract. If Contractor seeks approval in a region which IT did not seek or receive a service area approval under the original RFP (071I0000251), DCH may negotiate a contract modification covering that service area that is within the parameters of approved pricing already in place for other contractors already approved in the

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same county. Service area expansion will only be approved in those counties requiring additional capacity as determined by DCH.

3. Alternative Regions

Contractors may propose alternatives to the regions listed above under the following condition:

- One or more contiguous counties from other listed regions may be included in the service area for the Contract. The counties must be contiguous to the original region under Contract. Under this alternative, the proposed provider network and Enrollment Capacity shall be included with the original region. However, the Capitation Rates, under this alternative, must be specific for the contiguous county(ies) in addition to the regional Capitation Rates.

4. Contractor Minimum Capacity

The State will initiate cancellation of the Contractor if a Contractor has sought and received approval for regions 1, 9 or 10 and does not have a minimum total enrollment capacity of 25,000 from all product lines (Commericial, Medicare, and Medicaid) on or after January 1, 2001. The DCH will establish a transition plan for the orderly movement of Enrollees in accordance with Section I-O of the Contract. Exceptions to the cancellation will be in those instances where significant Enrollee disruptions will occur due to the lack of continuity of care with providers that are not contracted with any other Contractor in the same region.

II-E MEDICAID ELIGIBILITY AND CHCP ENROLLMENT

The Michigan Medicaid program arranges for and administers medical assistance to approximately 1.2 million Beneficiaries. This includes the categorically needy (those individuals eligible for, or receiving, federally-aided financial assistance or those deemed categorically needy) and the medically needy populations. Eligibility for Michigan's Medicaid program is based on a combination of financial and non-financial factors. Within the Medicaid eligible population, there are groups that must enroll in the CHCP, groups that may voluntarily enroll, and groups that are excluded from participation in the CHCP as follows:

1. Medicaid Eligible Groups Who Must Enroll in the CHCP:

- Families with children receiving assistance under the Financial Independence Program (FIP)
- Persons receiving Mich-Care Medicaid or Medicaid for pregnant women
- Persons under age 21 who are receiving Medicaid.
- Persons receiving Medicaid for caretaker relatives and families with dependent children who do not receive FIP
- Supplemental Security Income (SSI) Beneficiaries who do not receive Medicare
- Persons receiving Medicaid for the blind or disabled
- Persons receiving Medicaid for the aged

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2. Medicaid Eligible Groups Who May Voluntarily Enroll in the CHCP:
   - Migrants
   - Native Americans
   - Persons in the Traumatic Brain Injury program
   - Pregnant women who are in third trimester of pregnancy

3. Medicaid Eligible Groups Excluded From Enrollment in the CHCP:
   - Persons without full Medicaid coverage, including those in the State Medical Program or PlusCare
   - Persons with Medicaid who reside in an ICF/MR (intermediate care facilities for the mentally retarded), or a State psychiatric hospital.
   - Persons receiving long term care (custodial care) in a licensed nursing facility
   - Persons being served under the Home & Community Based Elderly Waiver
   - Persons enrolled in Children's Special Health Care Services (CSHCS)
   - Persons with commercial HMO coverage, including Medicare HMO coverage.
   - Persons in PACE (Program for All-inclusive Care for the Elderly)
   - Spend-down clients
   - Children in Foster Care or Child Care Institutions
   - Persons in the Refugee Assistance Program
   - Persons in the Repatriate Assistance Program
   - Persons with both Medicare and Medicaid eligibility

II-F ELIGIBILITY DETERMINATION

The State has the sole authority for determining whether individuals or families meet any of the eligibility requirements as specified for enrollment in the CHCP.

Individuals who attain eligibility due to a pregnancy are usually guaranteed eligibility for comprehensive services through 60 days post-partum or post-loss of pregnancy. Their newborns are usually guaranteed coverage for 60 days and may be covered for one full year.

II-G ENROLLMENT IN THE CHCP

1. Enrollment Services

The State is required to contract for services to help Beneficiaries make informed choices regarding their health care, assist with client satisfaction and access surveys, and assist Beneficiaries in the appropriate use of the Contractor's complaint and grievance systems. DCH contracts with an Enrollment Services contractor to contact and educate general Medicaid and CSHCS Beneficiaries about managed care and to enroll, disenroll, and change enrollment for these Beneficiaries. Although this Contract indicates that the enrollment and disenrollment process and related functions will be performed by DCH, generally, these activities are part of the Enrollment Services contract. Enrollment Services references to DCH are intended to indicate functions that will be performed by either DCH or the Enrollment Services contractor. All Contractors agree to work closely with DCH and provide necessary information, including provider files.

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2. Initial Enrollment

After a person applies to FIA for Medicaid, he or she will be assessed for eligibility in a Medicaid managed care program. If they are determined eligible for the CHCP, they will be given marketing material on the Contractors available to them, and the opportunity to speak with an Enrollee counselor to obtain more in-depth information and to get answers to any questions or concerns they may have. DCH will provide access to a toll-free number to call for information or to designate their preferred Contractor. Beneficiaries eligible for the CHCP will have full choice of Contractors within their county of residence. Beneficiaries must decide on the Contractor they wish to enroll in within 30 days from the date of approval of Medicaid eligibility. If they do not voluntarily choose a Contractor within 30 days of approval, DCH will automatically assign the Beneficiaries to Contractors within their county of residence.

Under the automatic enrollment process, Beneficiaries will be automatically assigned to Contractors based on performance of the Contractor in areas specified by DCH. DCH will automatically assign a larger proportion of Beneficiaries to Contractors with a higher performance ranking. The capacity of the Contractor to accept new Enrollees and to provide reasonable accessibility for the Enrollees also will be taken into consideration in automatic Beneficiary enrollment. Individuals in a family unit will be assigned together whenever possible. DCH has the sole authority for determining the methodology and criteria to be used for automatic enrollment.

3. Enrollment Lock-in

Except as stated in this subsection, enrollment into a Contractor's plan will be for a period of 12 months with the following conditions:

- At least 60 days before the start of each enrollment period and at least once a year, DCH, or the Enrollment Services contractor, will notify Enrollees of their right to disenroll;
- Enrollees will be provided with an opportunity to select any Contractor approved for their area during this open enrollment period;
- Enrollees will be notified that if they do nothing, their current enrollment will continue;
- Enrollees who choose to remain with the same Contractor will be deemed to have had their opportunity for disenrollment without cause and declined that opportunity;
- New Enrollees, those who have changed from one Contractor to another or are new to Medicaid eligibility, will have 90 days within which they may change Contractors without cause;
- Enrollees who change enrollment within the 90-day period will have another 90 days within which they may change Contractors without cause and this may continue throughout the year;
- An Enrollee who has already had a 90-day period with a particular Contractor will not be entitled to another 90-day period within the year with the same Contractor;
- Enrollees who disenroll from a Contractor will be required to change enrollment to another Contractor;

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- All such changes will be approved and implemented by DCH on a calendar month basis.

After October 1, 2000, and for the period October 1, 2000 through September 30, 2001 only, DCH may implement an additional open enrollment period. Implementation of this additional open enrollment period will be consistent with the conditions stated above

4. Rural Area Exception

This sub-section is reserved for Rural Area Exception that is included under proposed rules under the Balanced Budget Act. Upon issuing the final rule, consistent Contract amendments will be developed.

5. Enrollment date

Any changes in enrollment will be approved and implemented by DCH on a calendar month basis.

If a Beneficiary is determined eligible during a month, he or she is eligible for the entire month. In some cases, Enrollees may be retroactively determined eligible. Once a Beneficiary (other than a newborn) is determined to be Medicaid eligible, enrollment in the CHCP and assignment to a Contractor will occur on the first day of the month following the eligibility determination. Contractors will not be responsible for paying for health care services during a period of retroactive eligibility and prior to the date of enrollment in their health plan, except for newborns (Refer to II-G6). Only full-month capitation payments will be made to the Contractor.

If the Beneficiary is in an inpatient hospital setting on the date of enrollment (first day of the month), the Contractor will not be responsible for the inpatient stay or any charges incurred prior to the date of discharge. The Contractor will be responsible for all care from the date of discharge forward. Similarly, if an Enrollee is disenrolled from a Contractor and is in an inpatient hospital setting on the date of disenrollment (last day of the month), the Contractor will be responsible for all charges incurred until the date of discharge.

6. Newborn Enrollment

Newborns of eligible CHCP mothers who were enrolled at the time of the child's birth will be automatically enrolled with the mother's Contractor. The Contractor is responsible for submitting a newborn notification form to DCH. The Contractor will be responsible for all Covered Services for the newborn until notified otherwise by DCH. At a minimum, newborns are eligible for the month of their birth and may be eligible for up to one year or longer. The Contractor will receive a capitation payment for the month of birth and for all subsequent months of enrollment.

7. Open Enrollment

Open enrollment will occur for all Beneficiaries at least once every 12 months. Enrollees will be offered the choice to stay in the health plan they are in or to change to another Contractor within their county at the end of the 12-month lock-in.

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8. Automatic Re-enrollment

Enrollees who are disenrolled from a Contractor's plan due to loss of Medicaid eligibility will be automatically re-enrolled or assigned to the same Contractor should they regain eligibility within three months. If more than three months have elapsed, Beneficiaries will have full choice of Contractors within their county of residence.

9. Enrollment Errors by the Department

If DCH enrolls a non-eligible person with a Contractor, DCH will retroactively disenroll the person as soon as the error is discovered and will recoup the capitation paid to the Contractor. Contractor may then recoup payments from its providers if that is permissible under its provider contracts.

10. Enrollees who move out of the Contractor's Service Area

The Contractor agrees to be responsible for services provided to an Enrollee who has moved out of the Contractor's service area after the effective date of enrollment until the Enrollee is disenrolled from the Contractor. DCH will permit Contractor to submit information that an Enrollee has moved out of service area only if such information can be corroborated by an independent third party acceptable to DCH. DCH will expedite prospective disenrollments of Enrollees and process all such disenrollments effective the next available month after notification from FIA that the Enrollee has left the Contractor's service area. Until the Enrollee is disenrolled from the Contractor, the Contractor will receive a Capitation Rate for these Enrollees at a rate consistent with the highest rate approved for the Contractor. The Contractor is responsible for all medically necessary Covered Services for these Enrollees until they are disenrolled. The Contractor may use its utilization management protocols for hospital admissions and specialty referrals for Enrollees in this situation. Contractors are responsible for all medically necessary authorized services until a member is disenrolled from a plan. Contractors may require members to return to use network providers and provide transportation and Contractors may authorize out of network providers to provide medically necessary services. Enrollment of Beneficiaries who reside out of the service area of a Contractor before the effective date of enrollment will be considered an "enrollment error" as described above.

11. Disenrollment Requests Initiated by the Contractor

The Contractor may initiate special disenrollment requests to DCH based on Enrollee actions inconsistent with Contractor membership--for example, if there is fraud, abuse of the Contractor, or other intentional misconduct; or if, in the opinion of the attending PCP, the Beneficiary's behavior makes it medically infeasible to safely or prudently render Covered Services to the Enrollee. Special disenrollment requests are divided into three categories:

- Violent/life-threatening situations involving physical acts of violence; physical or verbal threats of violence made against Contractor providers, staff or the public at Contractor locations; or stalking situations.
- Fraud/misrepresentation involving alteration or theft of prescriptions, misrepresentation of Contractor membership, or unauthorized use of CHCP benefits.

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- Other noncompliance situations involving the failure to follow treatment plan; repeated use of non-Contractor providers; Contractor provider refusal to see the Enrollee; repeated emergency room use; and other situations that impede care.

Disenrollment requests may also be initiated by the Contractor if the Enrollee becomes eligible for services under Title V of the Social Security Act or is admitted to a nursing facility for custodial care. The Contractor must provide DCH with medical documentation to support this type of disenrollment request. Information must be provided in a timely manner using the format specified by DCH. DCH reserves the right to require additional information from the Contractor to assess the need for Enrollee disenrollment and to determine the Enrollee's eligibility for special services.

12. Medical Exception

The Beneficiary may request an exception to enrollment in the CHCP if he or she has a serious medical condition and is undergoing active treatment for that condition with a physician that does not participate with the Contractor at the time of enrollment. The Beneficiary must submit a medical exception request to DCH.

13. Disenrollment for Cause Initiated by the Enrollee

The Enrollee may request a disenrollment for cause from a Contractor's plan at any time during the enrollment period. Reasons cited in a request for disenrollment for cause may include poor quality care or lack of access to necessary specialty services covered under the Contract. Enrollees who are granted a disenrollment for cause will be required to change enrollment to another Contractor.

II-H SCOPE OF COMPREHENSIVE BENEFIT PACKAGE

1. Services Included

The Covered Services that the Contractor has available for Enrollees must include, at a minimum, the Covered Services listed below. The Contractor may limit services to those which are medically necessary and appropriate, and which conform to professionally accepted standards of care. Contractors must operate consistent with all applicable Medicaid provider manuals and publications for coverages and limitations. If new services are added to the Michigan Medicaid Program, or if services are expanded, eliminated, or otherwise changed, the Contractor must implement the changes consistent with State direction in accordance with the provisions of Contract Section I-T.

Although the Contractor must provide the full range of Covered Services listed below they may choose to provide services over and above those specified.

The services provided to Enrollees under this Contract include, but are not limited to, the following:

- Inpatient and outpatient hospital services
- Emergency services
- Practitioners' services (such as those provided by physicians, optometrists and dentists enrolled as a Medicaid Provider Type 10)

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- Chiropractic services
- Podiatry services
- Immunizations
- Well child/EPSDT for persons under age 21
- Transplant services
- Family planning services
- Pharmacy services
- Prosthetics & orthotics
- Durable medical equipment and supplies
- Certified nurse midwife services
- Certified pediatric and family nurse practitioner services
- Hospice services (if requested by the Enrollee)
- Transportation
- Ambulance and other emergency medical transportation
- Vision services
- Hearing & speech services, including hearing aids
- Therapies, (speech, language, physical, occupational)
- Diagnostic lab, x-ray and other imaging services
- Health education
- Home Health services
- Intermittent or short-term restorative or rehabilitative nursing care (in or out of a facility)
- Parenting and birthing classes
- Medically necessary weight reduction services
- End Stage Renal Disease services
- Mental health care up to 20 outpatient visits per Contract year
- Maternal and Infant Support Services (MSS/ISS)
- Outreach for included services, especially, pregnancy related and well-child care
- Out-of-state services authorized by the Contractor
- Treatment for sexually transmitted disease (STD)
- Blood lead follow-up services for individuals under the age of 21

2. Enhanced Services

In conjunction with the provision of Covered Services, the Contractor agrees to do the following:

- Place strong emphasis on programs to enhance the general health and well- being of Enrollees;
- Makes available health promotion programs to the Enrollees;
- Promote the availability of health education classes for Enrollees;
- Consider providing education for Enrollees with, or at risk for, a specific disability;
- Consider providing education to Enrollees, Enrollees' families, and other health care providers about early intervention and management strategies for various illnesses and/or exacerbations related to that disability or disabilities.

The Contractor agrees that the enhanced services must comply with the marketing and other relevant guidelines established by DCH. DCH will be receptive to innovation in the provision of health promotion services and, if appropriate, will seek any federal waivers necessary for the Contractor to implement a desired innovative program.

The Contractor may not charge an Enrollee a nominal fee for participating in health education services that fall under the definition of a Covered Service under this

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section of the Contract. A nominal fee may be charged to an Enrollee if the Enrollee elects to participate in programs beyond the Covered Services.

3. Services Covered Outside of the Contract

The following services are not Contractor requirements:

- Dental services
- Services provided by a school district and billed through the Intermediate School District
- Inpatient hospital psychiatric services (Contractors are not responsible for the physician cost related to providing psychiatric admission physical and histories. However, if physician services are required for other than psychiatric care during a psychiatric inpatient admission, the Contractor would be responsible for covering the cost, provided the service has been prior authorized and is a covered benefit.)
- Outpatient partial hospitalization psychiatric care
- Mental health services in excess of 20 outpatient visits each contract year
- Substance abuse services through accredited providers including:
  - Screening and assessment
  - Detoxification
  - Intensive outpatient counseling and other outpatient services
  - Methadone treatment
- Services provided to persons with developmental disabilities and billed through Provider Type 21
- Custodial care in a nursing facility
- Home and Community based waiver program services
- Personal care or home help services
- Transportation for services not covered in the CHCP
- Pharmacy and related services prescribed by providers under the State's Contract for specialty behavioral services or the State's Contract for specialty services for persons with developmental disabilities

4. Services Prohibited or Excluded Under Medicaid:

- Elective abortions and related services
- Experimental/Investigational drugs, procedures or equipment
- Elective cosmetic surgery

II-I SPECIAL COVERAGE PROVISIONS

Specific coverage and payment policies apply to certain types of services and providers, including the following:

- Emergency services
- Out-of-network services
- Family planning services
- Maternal and Infant Support Services
- Federally Qualified Health Center (FQHC)
- Co-payments
- Abortions
- Pharmacy services
- Early and Periodic Screening, Diagnosis & Treatment (EPSDT) Program
- Immunizations
- Transportation
- Transplant services
- Post-partum stays
- Communicable disease services
- Restorative health services
- Adolescent health centers

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1. Emergency Services

The Contractor must cover Emergency Services as well as medical screening exams consistent with the Emergency Medical Treatment and Active Labor Act (EMTALA) (41 USCS 1395 dd (a)). The Enrollee must be screened and stabilized without requiring prior authorization.

The Contractor must ensure that Emergency Services are available 24 hours a day and 7 days a week. The Contractor is responsible for payment of all out-of-plan or out-of-area Emergency Services and medical screening and stabilization services provided in an emergency department of a hospital consistent with the legal obligation of the emergency department to provide such services. The Contractor will not be responsible for paying for non-emergency treatment services that are not authorized by the Contractor.

(a) Emergency Transportation

The Contractor agrees to provide emergency transportation for Enrollees. In the absence of a contract between the emergency transportation provider and the Contractor, a properly completed and coded claim form for emergency transport, which includes an appropriate ICD-9-CM diagnosis code as described in Medicaid policy, will receive timely processing and payment by the Contractor.

(b) Professional Services

The Contractor agrees to provide professional services that are needed to evaluate or stabilize an emergency medical condition that is found to exist using a prudent layperson standard. Contractors acknowledge that hospitals that offer emergency services are required to perform a medical screening examination on emergency room clients leading to a clinical determination by the examining physician that an emergency medical condition does or does not exist. The Contractor further acknowledges that if an emergency medical condition is found to exist, the examining physician must provide whatever treatment is necessary to stabilize that condition of the Enrollee.

(c) Facility Services

The Contractor agrees to ensure that Emergency Services continue until the Enrollee is stabilized and can be safely discharged or transferred. If an Enrollee requires hospitalization or other health care services that arise out of the screening assessment provided by the emergency department, then the Contractor may require prior authorization for such services. However, such services shall be deemed prior authorized if the Contractor does not respond within the timeframe established under rules of the federal Balanced Budget Act of 1997 for responding to a request for authorization being made by the emergency department.

2. Out-of-Network Services

Services may be Contractor authorized either out of the area or out of the Contractor's network of providers. Unless otherwise noted in this Contract, the Contractor is responsible for coverage and payment of all emergency and authorized care provided outside of the established network. Out-of-network claims must be

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paid at established Medicaid fees that currently exist for paying participating Medicaid providers as established by Medicaid policy.

3. Family Planning Services

Family planning services include any medically approved diagnostic evaluation, drugs, supplies, devices, and related counseling for the purpose of voluntarily preventing or delaying pregnancy or for the detection or treatment of sexually transmitted diseases (STDs). Services are to be provided in a confidential manner to individuals of child bearing age including minors who may be sexually active, who voluntarily choose not to risk initial pregnancy, or wish to limit the number and spacing of their children.

The Contractor agrees:

- That Enrollees will have full freedom of choice of family planning providers, both in-plan and out-of-plan;
- To encourage the use of public providers in their network;
- To pay providers of family planning services who do not have contractual relationships with the Contractor, or who do not receive PCP authorization for the service at established Medicaid fee-for-service (FFS) fees that currently exist for paying participating Medicaid providers;
- To encourage family planning providers to communicate with PCPs once any form of medical treatment is undertaken;
- To maintain accessibility for family planning services through promptness in scheduling appointments, particularly for teenagers;
- That family planning services do not include treatment for infertility.

4. Maternal and Infant Support Services

In regard to MSS/ISS, the Contractor agrees:

- That maternal and infant support services are specialized preventive services provided to pregnant women, mothers and their infants to help reduce infant mortality and morbidity;
- That these support services are effectively provided by a multidisciplinary team of health professionals who concentrate on social services, nutrition, and health education;
- That it will ensure that the mothers and infants have proper nutrition, psychosocial support, transportation for all health services, assistance in understanding the importance of receiving routine prenatal care, Well Child Visits and immunizations, as well as other necessary health services, care coordination, counseling and social casework, Enrollee advocacy, and appropriate referral services;
- That the support services are intended for those Enrollees who are most likely to experience serious health problems due to psychosocial or nutritional conditions;
- That maternal and infant support services must be provided by certified providers.

The Contractor agrees that during the course of providing prenatal or infant care, support services will be provided if any of the following conditions are likely to affect the pregnancy:

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- disadvantageous social situation
- negative or ambivalent feelings about the pregnancy
- mother under age 18 and has no family support
- need for assistance to care for herself and infant
- mother with cognitive emotional or mental impairment
- nutrition problem
- need for transportation to keep medical appointments
- need for childbirth education
- abuse of alcohol or drugs or smoking

The Contractor agrees that infant support services are home based services and will be provided if any of the following conditions exist with the mother or infant:

- abuse of alcohol or drugs (especially cocaine) or smoking
- mother is under age 18 and has no family support
- family history of child abuse or neglect
- failure to thrive
- low birth weight (less than 2500 grams)
- mother with cognitive, emotional or mental impairment
- homeless or dangerous living/home situation
- any other condition that may place the infant at risk for death, illness or significant impairment

Due to the potentially serious nature of these conditions, some Enrollees will need the assistance of the FIA Children's Protective Services. The Contractor agrees to work cooperatively and on an ongoing basis with local FIA office to establish and maintain a referral protocol and working relationship.

Because of the investment of public dollars to improve the health status of children, it is intended that the annual collective dollars spent by all Contractors in each county for maternal and infant support services equal at least the base year's total expenditures for the same services. Through the reporting requirements specified in this Contract, DCH will monitor Contractors to ensure that expenditures for these services are used in this manner.

5. Federally Qualified Health Centers (FQHCs)

The Contractor agrees to provide Enrollees with access to services provided through a Federally Qualified Health Center (FQHC) if the Enrollee resides in the FQHC's service area and if the Enrollee requests such services. For purposes of this requirement, the service area will be defined as the county in which the FQHC is located. The Contractor must inform Enrollees of this right in their member handbooks. If a Contractor has an FQHC in its provider network and allows members to receive medically necessary services from the FQHC, the Contractor has fulfilled its responsibility to provide FQHC services and does not need to allow its members to access FQHC services out-of-network.

If a Contractor does not include an FQHC in its provider network and an FQHC exists in the service area (county), the Contractor will have to pay FQHC charges if an Enrollee member requests such services.

For services furnished on or after October 1, 1997, FQHCs are entitled, pursuant to the Social Security Act, to reasonable cost-based reimbursement as subcontractors of section 1903 (m) organizations. Section 4712(b)(2) requires that rates of payments between FQHCs and Managed Care Organizations (Health Plans) shall not be less than the amount of payment for a similar set of services with a non-

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FQHC. States are required to make supplemental payments, at least on a quarterly basis, for the difference between the rates paid by section 1903 (m) organizations (Health Plans) and the reasonable cost of FQHC subcontracts with the 1903 (m) organization (Health Plans). Beginning in Fiscal Year (FY) 2000, the difference states will be required to pay begins to phase down from 100 percent; specifically, 95 percent of reasonable cost in FY 2000, 2001, and 2002; 90 percent in FY 2003; and 85 percent in FY 2004.

FQHC services must be prior authorized by the Contractor, however the Contractor may not refuse to authorize medically necessary services if the Contractor does not have a FQHC in the network for the service area (county). Contractors may expect a sharing of information and data and appropriate network referrals from FQHCs.

6. Co-payments

The Contractor may subject Enrollees to co-payment requirements, consistent with state and federal guidelines. In regard to co-payments, the Contractor agrees that it will not implement co-payments without DCH approval and that co-payments will only be implemented following the annual open enrollment period. Enrollees must be informed of co-payments during the open enrollment period.

7. Abortions

Medicaid funds cannot be used to pay for elective abortions (and related services) to terminate pregnancy unless a physician certifies that the abortion is medically necessary to save the life of the mother. Elective abortions must also be covered if the pregnancy is a result of rape or incest. Treatment for medical complications occurring as a result of an elective abortion will be covered. Treatments for spontaneous, incomplete, or threatened abortions and for ectopic pregnancies will be covered.

8. Pharmacy

The Contractor may have a prescription drug management program that includes a drug formulary. DCH may review a formulary if Enrollee complaints regarding access have been filed regarding the formulary. The Contractor agrees to have a process to approve physicians' requests to prescribe any medically appropriate drug that is covered under the Medicaid fee-for-services program.

Drug coverages must include over-the-counter products such as insulin syringes, reagent strips, psyllium, and aspirin, as covered by the Medicaid fee-for-services program. Condoms must also be made available to all eligible Enrollees.

The Contractor agrees to act as DCH's third party administrator and reimburse pharmacies for psychotropic drugs. In the performance of this function:

(a) The Contractor must follow Medicaid Fee-For-Service utilization controls for Medicaid psychotropic prescriptions. The Contractor must prior authorize only the psychotropic drugs that are prior authorized by Medicaid Fee-For-Service.
(b) The Contractor agrees that it and its pharmacy benefit managers are precluded from billing manufacturer rebates on psychotropic drugs.
(c) The Contractor agrees to provide payment files to DCH in the format and manner prescribed by DCH.
(d) DCH agrees to use the payment files to reimburse the Contractor for the payments made on behalf of CMHSPs using the following formula:

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- [*]% of all anti-psychotics
- [*]% of antiparkinson drugs, anticholinergic
- [*]% all other psychotropic drugs

(e) In order to meet the terms of this sub-section, the Contractor will have to enroll with DCH as a Medicaid pharmacy provider; however, that enrollment is limited to fulfilling the terms of this part of the Contract.

(f) Contractor is responsible for covering lab and x-ray services related to the ordering of psychotropic drug prescriptions for CMHSP clients who are also Enrollees of the contractor's health plan but may limit access to its contracted lab and x-ray providers.

9. Well Child Care/Early and Periodic Screening, Diagnosis & Treatment (EPSDT) Program

Well Child/EPSDT is a Medicaid child health program of early and periodic screening, diagnosis and treatment services for children, adolescents, and young adults under the age of 21. It supports two goals: to ensure access to necessary health resources, and to assist parents and guardians in appropriately using those resources. The Contractor agrees to provide the following program:

(a) As specified in federal regulations, the screening component includes a general health screening most commonly known as a periodic well-child exam. The required Well Child/EPSDT screening guidelines, based on the American Academy of Pediatrics' recommendations for preventive pediatric health care, include:

- health and developmental history
- developmental/behavioral assessment
- age appropriate unclothed physical examination
- height and weight measurements, and age appropriate head circumference
- blood pressure for children 3 and over
- immunization review and administration of appropriate immunizations
- health education including anticipatory guidance
- nutritional assessment
- hearing, vision and dental assessments
- lead toxicity screening ages 1-5, with blood sample for lead level determination as indicated
- interpretive conference and appropriate counseling for parents or guardians

Additionally, objective testing for developmental behavior, hearing and vision must be performed in accordance with the periodicity schedule included in Medicaid policy. Laboratory services for tuberculin testing, hematocrit, urinalysis, hemoglobin, or other needed testing as determined by the physician must be provided.

(a) Vision services under Well Child/EPSDT must include at least diagnosis and treatment for defective vision, including glasses if appropriate.

(b) Dental services under Well Child/EPSDT must include at least relief of pain and infections, restoration of teeth, and maintenance of dental health. (The Contractor is responsible for screening and referral only.)

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(c) Hearing services must include at least diagnosis and treatment for hearing defects, including hearing aids as appropriate.

(d) Other health care, diagnostic services, treatment, or services covered under the State Medicaid Plan necessary to correct or ameliorate defects, physical or mental illnesses, and conditions discovered during a screening. A medically necessary service may be available under Well Child/EPSDT if listed in a federal statute as a potentially covered service, even if Michigan's Medicaid program does not cover the service under its State plan for Medical Assistance Program.

Appropriate referrals must be made for a diagnostic or treatment service determined to be necessary. Oral screening should be part of a physical exam; however, each child must have a direct referral to a dentist after age two. It is the Contractor's responsibility to ensure that the child is seen by an appropriate dental provider. Children should also be referred to a hearing and speech clinic, optometrist or ophthalmologist, or other appropriate provider for objective hearing and vision services as necessary. Referral to community mental health services also may be appropriate. If a child is found to have elevated blood lead levels in accordance with standards disseminated by DCH, a referral should be made to the local health department for follow-up services that may include an epidemiological investigation to determine the source of blood lead poisoning.

The Contractor shall provide or arrange for outreach services to Medicaid beneficiaries who are due or overdue for well-child visits. Outreach contacts may be by phone, home visit or mail. The Contractor will meet this requirement by contracting with local health departments and the provision to local health departments of the names of children due or overdue for well child visits.

10. Immunizations

The Contractor agrees to provide all Enrollees with all vaccines and immunizations in accordance with the Advisory Committee on Immunization Practices (ACIP) guidelines. The Contractor must ensure that all providers use vaccines available free under the Vaccine for Children (VFC) program for children 18 years old and younger, and use vaccines for adults such as hepatitis B available at no cost from local health departments under the Vaccine Replacement Program. Immunizations should be given in conjunction with Well-Child/EPSDT care. The Contractor must participate in the locally accessed Michigan Children's Immunization Registry that will maintain a database of child vaccination histories and enable tracking and recall.

Contractor will be responsible for the reimbursement of immunization that Enrollees have obtained from local health departments at Medicaid-Fee-For-Service rates. This policy is effective without Contractor prior authorization and regardless of whether a contract exists between the Contractor and the local health departments.

11. Transportation

The Contractor must ensure transportation and travel expenses determined to be necessary for Enrollees to secure medically necessary medical examinations and treatment. The Contractor agrees to provide a description, upon request, of the method(s) used to ensure this requirement is met. Contractors will receive supplemental funding for non-emergency transportation.

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12. Transplant Services

The Contractor agrees to cover all costs associated with transplant surgery and care. Related care may include but is not limited to organ procurement, donor searching and typing, harvesting of organs, related donor medical costs. Cornea and kidney transplants and related procedures are covered services. Extrarenal organ transplants (heart, lung, heart-lung, liver, pancreas, bone marrow including allogenic, autologous and peripheral stem cell harvesting, and small bowel) must be covered on a patient-specific basis when determined medically necessary according to currently accepted standards of care. The Contractor must have a process in place to evaluate, document, and act upon such requests.

13. Post-Partum Stays

Contractors agree to cover a minimum length of post-partum stay at a hospital that is consistent with the minimum hospital stay standards of the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists.

14. Communicable Disease Services

The Contractor agrees that Enrollees may receive treatment services for communicable diseases from local health departments without prior authorization by the Contractor. For purposes of this section, communicable diseases are HIV/AIDS, STDs, tuberculosis, and vaccine-preventable communicable diseases.

To facilitate coordination and collaboration, Contractors are encouraged to enter into agreements with local health departments. Such agreements should provide details regarding confidentiality, service coordination and instances when local health departments will provide direct care services for the Contractor's Enrollees. Agreements should also discuss, where appropriate, reimbursement arrangements between the Contractor and the local health department.

If a local agreement is not in effect, and an Enrollee receives services for a communicable disease from a local health department, the Contractor is responsible for payment to the local health department at established Medicaid fee-for-service fees that currently exist for participating providers.

15. Restorative Health Services

The Contractor is responsible for providing up to 45 days of restorative health care services as long as medically necessary and appropriate for Enrollees.

Restorative health services means intermittent or short-term "restorative" or rehabilitative nursing care that may be provided in or out of health care facilities.

The Contractor will be expected to help facilitate support services such as home help services that are not the direct responsibility of the Contractor but are services to which Enrollees may be entitled. Such care coordination should be provided consistent with the individual or person-centered planning that is necessary for Enrollee members with special health care needs.

16. School Based/School Linked (Adolescent) Health Centers

The Contractor acknowledges that Enrollees may choose to obtain services from a School Based/School Linked Health Center (SBLHC) without prior authorization from

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the Contractor. If the SBLHC does not have a contractual relationship with the Contractor, then the Contractor is responsible for payment to the SBLHC at Medicaid fee-for-service rates in effect on the date of service.

Contractors may contract with an SBLHC to deliver Covered Services as part of the Contractor's network. Covered Services shall be medically necessary and administered, or arranged for, by a designated PCP. The SBLHC will meet the Contractor's written credentialling and re-credentialling policies and procedures for ensuring quality of care and ensuring that all providers rendering services to Enrollees are licensed by the State and practice within their scope of practice as defined for them in Michigan's Public Health Code.

If a contract exists between the SBLHC and the Contractor, then the SBLHC is to be reimbursed according to the provisions of the contractual agreement.

17. Hospice Services

Contractor is responsible for all medically necessary and authorized hospice services, including the "room and board" component of the hospice benefit when provided in a nursing home. Members who have elected the hospice benefit will not be disenrolled after 45 days in a nursing home as otherwise permitted under subsection (15) of the section.

II-J OBSERVANCE OF FEDERAL, STATE AND LOCAL LAWS

The Contractor agrees that it will comply with all state and federal statutes, regulations and administrative procedures that become effective during the term of this Contract. Federal regulations governing contracts with risk-based managed care plans are specified in section 1903(m) of the Social Security Act and 42 CFR Part 434, and will govern this Contract. The State is not precluded from implementing any changes in state or federal statutes, rules or administrative procedures that become effective during the term of this Contract and will implement such changes pursuant to Contract Section (I-T).

1. Special Waiver Provisions for CHCP

DCH's waiver renewal application to HCFA under the auspices of section 1915(b)(1)(2), requesting that section 1902 (a)(23) of the Social Security Act be waived, has been approved. The renewal was approved by HCFA for the period March 28, 2000 through March 27, 2002. Under this waiver, Beneficiaries will be enrolled with a Contractor in the county of their residence. All health care for Enrollees will be arranged for or administered by the Contractor only. Federal approval of the waiver is required prior to commitment of the federal financing share of funds under this Contract. No other waiver is necessary to implement this Contract.

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2. Fiscal Soundness of the Risk-Based Contractor

Federal regulations require that the risk-based Contractors maintain a fiscally solvent operation and DCH has the right to evaluate the ability of the risk-based Contractor to bear the risk of potential financial losses, or to perform services based on determinations of payable amounts under the Contract. The State will require a minimum net worth and a set reserve amount as a condition of maintaining status as a Contractor.

3. Suspended Providers

Federal regulations and State law preclude reimbursement for any services ordered, prescribed, or rendered by a provider who is currently suspended or terminated from direct and indirect participation in the Michigan Medicaid program or federal Medicare program. An Enrollee may purchase services provided, ordered, or prescribed by a suspended or terminated provider, but no Medicaid funds may be used. DCH publishes a list of providers who are terminated, suspended or otherwise excluded from participation in the program. The Contractor must ensure that its provider networks do not include these providers.

Pursuant to Section 1932(d)(1) of the Social Security Act, a Contractor may not knowingly have a director, officer, partner, or person with beneficial ownership of more than 5% of the entity's equity who is currently debarred or suspended by any federal agency. Contractors are also prohibited from having an employment, consulting, or any other agreement with a debarred or suspended person for the provision of items or services that are significant and material to the Contractor's contractual obligation with the State.

The United States General Services Administration (GSA) maintains a list of parties excluded from federal programs. The "excluded parties lists" (EPLS) and any rules and/or restrictions pertaining to the use of EPLS data can be found on GSA's homepage at the following Internet address: www.arnet.gov/epls.

4. Public Health Reporting

State law requires that health professionals comply with specified reporting requirements for communicable disease and other health indicators. The Contractor agrees to ensure compliance with all such reporting requirements through its provider contracts.

5. Compliance with HCFA Regulation.

As required by 42 CFR Part 434.22, DCH will deny payments for new enrollees when payments for those Enrollees are denied by HCFA pursuant to 42 CFR 434.67(e).

6. Advanced Directives Compliance.

The Contractor shall comply with provisions for advance directives as required under 42 C.F.R.434.28.

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7. Medicaid Policy.

As required, Contractors shall comply with provisions of Medicaid policy developed under the formal policy consultation process, as established by the Medical Assistance Program.

II-K CONFIDENTIALITY

All Enrollee information, medical records, data and data elements collected, maintained, or used in the administration of this Contract shall be protected by the Contractor from unauthorized disclosure. The Contractor must provide safeguards that restrict the use or disclosure of information concerning Enrollees to purposes directly connected with its administration of the Contract.

The Contractor must have written policies and procedures for maintaining the confidentiality of data, including medical records, client information, appointment records for adult and adolescent sexually transmitted disease, and family planning services.

II-L CRITERIA FOR CONTRACTORS

The Contractor agrees to maintain its capability to deliver Covered Services to Enrollees by meeting the following criteria:

1. Administrative and Organizational Criteria

The Contractor will:

- Provide organizational and administrative structure and key specified personnel;
- Provide management information systems capable of collecting processing, reporting and maintaining information as required;
- Have a governing body that meets the requirements defined in this Contract;
- Meet the specified administrative requirements, i.e., quality improvement, utilization management, provider network, reporting, member services, provider services, staffing;
- Be or has applied for accreditation as a managed care organization by either the National Committee for Quality Assurance (NCQA) or Joint Commission on Health Care Organizations (JCAHO) no later than March 31, 2001;
- Be incorporated within the State of Michigan.

2. Financial Criteria

The Contractor agrees to comply with all HMO financial requirements and maintain financial records for its Medicaid activities separate from other financial records.

3. Provider Network and Health Service Delivery Criteria

The Contractor:

- has a network of qualified providers in sufficient numbers and locations to provide appropriate access to Covered Services;
- provides or arranges appropriate accessible care 24 hours a day, 7 days a week to the enrolled population.
- has local agreements with DCH contracted behavioral health and developmental disability providers and coordinates care.

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II-M CONTRACTOR ORGANIZATIONAL STRUCTURE, ADMINISTRATIVE SERVICES, FINANCIAL REQUIREMENTS AND PROVIDER NETWORKS

1. Organizational Structure

The Contractor will maintain an administrative and organizational structure that supports a high quality, comprehensive managed care program. The Contractor's management approach and organizational structure will ensure effective linkages between administrative areas such as: provider services, member services, regional network development, quality improvement and utilization review, grievance/complaint review, and management information systems.

The Contractor will be organized in a manner that facilitates efficient and economic delivery of services that conforms to acceptable business practices within the State. The Contractor will employ senior level managers with sufficient experience and expertise in health care management, and must employ or contract with skilled clinicians for medical management activities.

The Contractor must not include persons who are currently suspended or terminated from the Medicaid program in its provider network or in the conduct of the Contractor's affairs.

The Contractor will provide, upon request from DCH, a copy of the current organizational chart with reporting structures, names, and positions. A written narrative which documents the operation of the organization and the educational background, relevant work experience, and current job description for the key personnel identified in the organizational chart must be available upon request.

The Contractor will provide, upon request, a disclosure statement fully disclosing to DCH the nature and extent of any contracts or arrangements between the individuals responsible for the conduct of the Contractor's affairs (or their immediate families, or any legal entity in which they or their families have a financial interest exceeding 5% of the stock or assets of the entity) and the Contractor or a provider or other person concerning any financial relationship with the Contractor. The disclosure statements must be signed by each person listed and notarized. DCH must be notified in writing of a substantial change in the facts set forth in the statement not more than 30 days from the date of the change.

The Contractor must provide a completed "Authorization for Release of Information" form to DCH for each employee serving in a key position (i.e., Administrator, Medical Director, Chief Financial Officer, Management Information Systems Director). This form must be completed and submitted to DCH for every new employee hired to serve in a key position with the Contractor.

Information required to be disclosed in this section shall also be available to the Department of Attorney General, Health Care Fraud Division.

2. Administrative Personnel

The Contractor will have sufficient administrative staff and organizational components to comply with all program standards. The Contractor shall ensure that all staff has appropriate training, education, experience, licensure as appropriate, liability coverage, and orientation to fulfill the requirements of the positions. Resumes for key personnel must be available upon request from DCH. Resumes must indicate the type and amount of experience each person has relative to the position.

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The Contractor must promptly provide written notification to DCH of any vacancies of key positions and must make every effort to fill vacancies in all key positions with qualified persons as quickly as possible. The Contractor shall inform DCH in writing within seven (7) days of staffing changes in the following key positions:

- Administrator (Chief Executive Officer)
- Medical Director
- Chief Financial Officer
- Management Information System Director

The Contractor shall provide the following positions (either through direct employment or contract):

(a) Executive Management

A full time administrator with clear authority over general administration and implementation of requirements set forth in the Contract including responsibility to oversee the budget and accounting systems implemented by the Contractor. The administrator shall be responsible to the governing body for the daily conduct and operations of the Contractor's plan.

(b) Medical Director

The medical director shall be a Michigan-licensed physician (MD or DO) and shall be actively involved in all major clinical program components of the Contractor's plan including review of medical care provided, medical professional aspects of provider contracts, and other areas of responsibility as may be designated by the Contractor. The medical director shall devote sufficient time to the Contractor's plan to ensure timely medical decisions, including after hours consultation as needed. The medical director shall be responsible for managing the Contractor's Quality Assessment and Performance Improvement Program. The medical director shall ensure compliance with state and local reporting laws on communicable diseases, child abuse and neglect.

(c) Quality Improvement/Utilization Director

A full time quality improvement/utilization director who is either the Contractor's medical director, or a Michigan licensed physician or registered nurse who directly reports to the medical director and adequate staff to support quality improvement and utilization review activities.

(d) Chief Financial Officer

Full-time chief financial officer to oversee the budget and accounting systems implemented by the Contractor.

(e) Support/Administrative Staff

Adequate clerical and support staff to ensure appropriate functioning of the Contractor's operation.

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(f) Member Services Staff

Staff to coordinate communications with Enrollees and to act as Enrollee advocates. There shall be sufficient member service staff to enable Enrollees to receive prompt resolution of their problems or inquiries.

(g) Provider Services Staff

Staff to coordinate communications between the Contractor and its subcontractors and other providers. There shall be sufficient provider services staff to enable providers to receive prompt resolution of their problems or inquiries.

(h) Grievance/Complaint Coordinator

Staff to coordinate, manage, and adjudicate member and provider grievances.

(i) Management Information System (MIS) Director

Full-time MIS director to oversee the data management system, and to ensure that all reporting and claims payments are timely and accurate.

3. Administrative Requirements

The Contractor agrees to have the following policies, processes, and plans in place.

- written policies, procedures and an operational plan for management information systems;
- a process to review and authorize all network provider contracts;
- a process to credential and monitor credentials of all healthcare personnel;
- a process to identify and address instances of fraud and abuse;
- a process to review and authorize contracts established for reinsurance and third party liability if applicable;
- policies that comply with all federal and state business requirements;
- the Contractor must comply with all Contract reporting requirements; and
- designated liaisons - these must include a management information system (MIS) liaison and a general management liaison. All communication between the Contractor and DCH must occur through the designated liaisons unless otherwise specified by DCH. The general management liaison will also be designated as the authorized Contractor expediter pursuant to Contract Section III-B.

All policies, procedures, and clinical guidelines that the Contractor follows must be in writing and available on request to DCH and/or HCFA. All medical records, reporting formats, information systems, liability policies, provider network information and other detail specific to performing the contracted services must be available on request to DCH and/or HCFA.

4. Management Information Systems

The Contractor will have available a claims processing and management information system sufficient to support provider payments and data reporting between the Contractor and DCH. The Contractor must be capable of controlling, processing, and paying providers for services rendered to Contractor Enrollees. The Contractor

must collect service-specific procedures and diagnosis data, to price specific procedures or encounters (depending on the agreement between the provider and the Contractor), and maintain detailed records of remittances to providers. The Contractor is responsible for annual IRS form 1099 reporting of provider earnings.

Management information systems capabilities are necessary for at least the following areas:

- Member enrollment
- Provider enrollment
- Third party liability activity
- Claims payment
- Grievance and complaint tracking
- Tracking and recall for immunizations, well-child visits/EPSDT, and other services as required by DCH
- Encounter reporting
- Quality reporting
- Member access and satisfaction

5. Governing Body

Each Contractor will have a governing body that has a minimum of 1/3 of its membership consisting of adult Enrollees who are not compensated officers, employees, stockholders who own more than 5% of the shares of the Contractor's plan, or other individuals responsible for the conduct of, or financially interested in, the Contractor's affairs. The Contractor must have written policies and procedures detailing how Enrollee board members will be elected, the length of the term, filling of vacancies, notice to Enrollees and subscribers, etc. The governing body will ensure adoption and implementation of written policies governing the operation of the Contractor's plan. The Enrollee board members must have the same responsibilities as other board members in the development of policies governing the operation of the Contractor's plan. The administrator or executive officer that oversees the day-to-day conduct and operations of the Contractor will be responsible to the governing body. The governing body must meet at least quarterly, and must keep a permanent record of all proceedings that is available to DCH and/or HCFA on request.

6. Provider Network in the CHCP

(a) General

The Contractor is solely responsible for arranging and administering Covered Services to Enrollees. Covered Services shall be medically necessary and administered, or arranged for, by a designated PCP. Enrollees shall be provided with an opportunity to select their PCP. If the Enrollee does not choose a PCP at the time of enrollment, it is the Contractor's responsibility to assign a PCP within one month of the effective date of enrollment. If the Contractor cannot honor the Enrollee's choice of the PCP, the Contractor must contact the Enrollee to allow the Enrollee to either make a choice of an alternative PCP or to disenroll. The Contractor must notify all Enrollees assigned to a PCP whose provider contract will be terminated and assist them in choosing a new PCP prior to the termination of the provider contract.

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The Contractor must ensure that the provider network:

- provides available, accessible and adequate numbers of facilities, locations and personnel for the provision of Covered Services.
- guarantees that emergency services are available seven days a week, 24-hours per day.
- demonstrates that it can maintain a delivery system of sufficient size and resources to offer quality care that accommodates the needs of the enrolled Beneficiaries within each enrollment area.
- assures that contracted PCPs provide or arrange for coverage of services 24 hours a day, 7 days a week and PCPs must be available to see patients a minimum of 20 hours per practice location per week.
- responds to the cultural, racial and linguistic needs (including interpretive services as necessary) of the Medicaid population.
- is described in the provider files for PCPs and other providers that are submitted to the Department's Enrollment Services Contractor.
- will have sufficient capacity to handle the maximum number of Enrollees specified under this Contract.

Provider files will be used to give Beneficiaries information on available Contractors and to ensure that the provider networks identified for Contractors are adequate in terms of number, location, and hours of operation. The Contractor will ensure:

- that it will provide to DCH's Enrollment Services contractor provider files which contain a complete description of the provider network available to Enrollees;
- that provider files will be submitted in the format specified by DCH;
- that provider files will be updated as necessary to reflect the existing provider network;
- that provider files will be submitted to DCH's Enrollment Services contractor in a timely manner;
- that it will provide to DCH's Enrollment Services contractor a description of the Contractor's service network, including but not limited to: the specialty and hospital network available, arrangements for provision of medically necessary non-contracted specialty care; any family planning services network available, any affiliations with Federally Qualified Health Centers, Rural Health Clinics, and Adolescent Health Centers; arrangements for access to obstetrical and gynecological services; availability of case management or care coordination services; and arrangements for provision of ancillary services. The description will be updated as necessary;
- that the services network will be submitted to DCH's Enrollment Services contractor in a timely manner in the format requested

The Contractor will ensure:

- that selected PCPs are accessible taking into account travel time, availability of public transportation and other factors that may determine accessibility;
- that primary care and hospital services will be available to Enrollees within 30 minutes or 30 miles travel. Exceptions to this standard may be granted if the Contractor documents that no other network or non-network provider is accessible within the 30 minutes or 30 miles travel time. For pharmacy services, the State's expectations are that the Contractor will ensure access within 30 minutes travel time and that services will be available during evenings and on weekends;
- that reasonable access to specialists will be based on the availability and distribution of such specialists;

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- that adequate access exists for ancillary services such as pharmacy services, durable medical equipment services, home health services, and Maternal and Infant Support Services;
- that arrangements for laboratory services will be through only those laboratories with CLIA certificates;
- that all ancillary providers and facilities must be appropriately licensed or certified if required under 1978 PA 368, as amended.

(b) Mainstreaming

DCH considers mainstreaming of Enrollees into the broader health delivery system to be important. The Contractor must have guidelines and a process in place to ensure that Enrollees are provided Covered Services without regard to race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual preference, or physical or mental handicap. In addition, the Contractor must ensure that:

- Enrollees will not be denied a Covered Service or availability of a facility or provider identified in this Contract.

- Network providers will not intentionally segregate Enrollees in any way from other persons receiving health care services.

(c) Public and Community Providers and Organizations

Contractors must work closely with local public and private community-based organizations and providers to address prevalent health care conditions and issues. Such agencies and organizations include local health departments, local FIA offices, family planning agencies, Substance Abuse Coordinating Agencies, community and migrant health centers, school based and adolescent health centers, and local or regional consortiums centered around various health conditions. Local coordination and collaboration with these entities will make a wider range of essential health care and support services available to the Contractor's Enrollees. Each county has a different array of these providers, and agencies or organizations. Contractors are encouraged to coordinate with these entities through participation of their provider networks in Michigan's county-based community health assessment and improvement process and multipurpose human services collaborative bodies.

A local coordination matrix is provided in the Appendix of this Contract. The Contractor is encouraged to use this document as a guide for establishing coordination and collaboration practices and protocols with local public health agencies. To ensure that the services provided by these agencies are available to all Contractors, an individual Contractor shall not require an exclusive contract as a condition of participation with the Contractor.

It is also beneficial for Contractors to collaborate with non-profit organizations that have maintained a historical base in the community. These entities are seen by many Enrollees as "safe harbors" due to their familiarity with the cultural standards and practices within the community. For example, adolescent health centers are specifically designed to be accessible and acceptable, and are viewed as a "safe harbor" where adolescents will seek rather than avoid or delay needed services.

(d) Local Behavioral Health and Developmental Disability Provider Agreements

Some Enrollees in each Contractor's plan may also be eligible for services provided by Behavioral Health Services and Services for Persons with Developmental Disabilities managed care programs. Contractors are not responsible for the direct delivery of specified behavioral health and developmental disability services. The Contractor will establish and maintain local agreements with behavioral health and developmental disability agencies or organizations contracting with the State.

Contractors must ensure that local agreements address the following issues:

- Emergency services
- Pharmacy and laboratory service coordination
- Medical coordination
- Data and reporting requirements
- Quality assurance coordination
- Grievance and complaint resolution
- Dispute resolution

Examples of local agreements are included in the Appendix of this Contract.

(e) Network Changes

Contractors will notify DCH within seven (7) days of any changes to the composition of the provider network that affects the Contractor's ability to make available all Covered Services in a timely manner. Contractors will have procedures to address changes in its network that negatively affect access to care. Changes in provider network composition that DCH determines to negatively affect Enrollees' access to Covered Services may be grounds for sanctions or Contract termination.

If the Contractor expands the PCP network within a county and can serve more Enrollees the Contractor may submit a request to DCH to increase capacity. The request must include details of the changes that would support the increased capacity. Contractor must use the format specified by DCH to describe network capacity.

(f) Provider Contracts

In addition to HMO licensure requirements, Contractor provider contracts will meet the following criteria:

- Prohibit the provider from seeking payment from the Enrollee for any Covered Services provided to the Enrollee within the terms of the Contract and require the provider to look solely to the Contractor for compensation for services rendered. No cost-sharing or deductibles can be collected from Enrollees. Co-payments are only permitted with DCH approval.
- Require the provider to cooperate with the Contractor's quality improvement and utilization review activities.
- Include provisions for the immediate transfer of Enrollees to another Contractor PCP if their health or safety is in jeopardy.

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- Cannot prohibit a provider from discussing treatment options with Enrollees that may not reflect the Contractor's position or may not be covered by the Contractor.
- Cannot prohibit a provider from advocating on behalf of the Enrollee in any grievance or utilization review process, or individual authorization process to obtain necessary health care services.
- Require providers to meet Medicaid accessibility standards as established in Medicaid policy.

In accordance with Section 1932 (b)(7) of the Social Security Act as implemented by Section 4704(a) of the Balanced Budget Act, Contractors may not discriminate with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of provider's license or certification under applicable State law, solely on the basis of such license or certification. This provision should not be construed as an "any willing provider" law, as it does not prohibit Contractors from limiting provider participation to the extent necessary to meet the needs of the Enrollees. This provision also does not interfere with measures established by Contractors that are designed to maintain quality and control costs consistent with the responsibility of the organization.

(g) Disclosure of Physician Incentive Plan

Contractors will annually disclose to DCH the information on their provider incentive plans listed in 42 CFR 417.479(h)(1) and 417.479(i), as required in 42 CFR 434.70(a)(3), in order to determine whether the incentive plans meet the requirements of 42 CFR 417.479 (d) -- (g) when there exists compensation arrangements under the Contract where payment for designated health services furnished to an individual on the basis of a physician referral would otherwise be denied under Section 1903 (s) of the Social Security Act. The Contractor will provide the information on its physician incentive plans listed in 42 CFR 417.479(h)(3) to any Enrollee.

(h) Provider Credentialling

The Contractor will have written credentialling and re-credentialling (at least every two years) policies and procedures for ensuring quality of care and ensuring that all providers rendering services to their Enrollees are licensed by the State and are qualified to perform their services throughout the life of the Contract. The Contractor must ensure that network providers residing and providing services in bordering states meet all applicable licensure and certification requirements within their state. The Contractor also must have written policies and procedures for monitoring its providers and for sanctioning providers who are out of compliance with the Contractor's medical management standards.

(i) PCP Standards

The Contractor must offer its Enrollees freedom of choice in selecting a PCP. The Contractor will have written policies and procedures describing how Enrollees choose and are assigned to a PCP, and how they may change their PCP. The PCP is responsible for supervising, coordinating and providing all primary care to each assigned Enrollee. In addition, the PCP is responsible for initiating referrals for specialty care, maintaining continuity of each Enrollee's health care, and maintaining the Enrollee's medical record which includes documentation of all services provided by the PCP as well as any specialty or referral services.

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The Contractor will allow a specialist to perform as a PCP when the Enrollee's medical condition warrants management by a physician specialist. This may be necessary for those Enrollees with conditions such as diabetes, end-stage renal disease or other chronic disease or disability. The need for management by a physician specialist should be determined on a case-by-case basis in consultation with the Enrollee. If the Enrollee disagrees with the Contractor's decision, the Enrollee should be informed of his or her right to file a grievance with the Contractor and/or to file an appeal with DCH.

The Contractor will ensure that there is a reliable method and system for providing 24 hour access to urgent care and emergency services 7 days a week. All PCPs within the network must have information on the system and must reinforce with their Enrollees the appropriate use of health care services. Routine physician and office visits must be available during regular and scheduled office hours. Provisions must be available for obtaining urgent care 24 hours a day. Urgent care may be provided directly by the PCP or directed by the Contractor through other arrangements. Emergency Services must always be available.

Direct contact with a qualified clinical staff person must be available through a toll-free telephone number at all times.

At a minimum, the Contractor shall have or provide one full-time PCP per 2,000 members. This ratio shall be used to determine maximum Enrollment Capacity for the Contractor in an approved service area.

The Contractor will assign a PCP who is within 30 minutes or 30 miles travel time to the Enrollee's home, unless the Enrollee chooses otherwise. Exceptions to this standard may be granted if the Contractor documents that no other network or non-network provider is accessible within the 30 minute or 30 mile travel time. The Contractor will take the availability of handicap accessible public transportation into consideration when making PCP assignments.

PCPs must be available to see Enrollees a minimum of 20 hours per practice location per week. This provision may be waived by DCH in response to a request supported by appropriate documentation. Specialists are not required to meet this standard for minimum hours per practice location per week. In the event that a specialist is assigned to act as a PCP, the Enrollee must be informed of the specialist's business hours. In circumstances where teaching hospitals use residents as providers in a clinic and a supervising physician is designated as the PCP by the Contractor, the supervising physician must be available at least 20 hours per practice location per week.

The Contractor will ensure that some providers offer evening and weekend hours of operation in addition to scheduled daytime hours. The Contractor will provide notice to Enrollees of the hours and locations of service for their assigned PCP.

The Contractor will monitor waiting times to get appointments with providers, as well as the length of time actually spent waiting to see the provider. This data must be reported to DCH upon request. The Contractor will have established

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criteria for monitoring appointment scheduling for routine and urgent care and for monitoring waiting times in provider offices. These criteria must be submitted to DCH upon request.

The Contractor will ensure that a maternity care provider is designated for an enrolled pregnant woman for the duration of her pregnancy and postpartum care. A maternity care provider is a provider meeting the Contractor's credentialling requirements and whose scope of practice includes maternity care. An individual provider must be named as the maternity care provider to assure continuity of care. An OB/GYN clinic or practice cannot be designated as a PCP or maternity care provider. Designation of individual providers within a clinic or practice is appropriate as long as that individual, within the clinic or practice, agrees to accept responsibility for the Enrollees care for the duration of the pregnancy and post-partum care.

For maternity care, the Contractor will be able to provide initial prenatal care appointments for enrolled pregnant women according to standards developed by the CAC and the QIC.

II-N PAYMENT TO PROVIDERS

The Contractor will make timely payments to all providers for Covered Services rendered to Enrollees. With the exception of newborns, the Contractor will not be responsible for any payments owed to providers for services rendered prior to a Beneficiary's enrollment with the Contractor's plan. Except for newborns, payment for services provided during a period of retroactive eligibility will be the responsibility of DCH.

1. Electronic Billing Capacity

   The Contractor must meet the following timeframes for electronic billing capacity and may require its providers to meet the same standard as a condition for payment:

   (a) Be capable of accepting electronic billing for HCFA 1500 and UB 92 no later than May 31, 2000;
   (b) Be capable of accepting electronic billing for UB 92 (Inpatient and Outpatient Claims) with Medicare format standards no later than September 30, 2000;
   (c) Be capable of accepting electronic billing for HCFA 1500 claims with Medicare format standards no later than December 31, 2000.

2. Prompt Payment

   Contractors must meet the prompt payment requirements as stated in 2000 PA 187.

3. Payment Resolution Process

   The Contractor will have an effective provider appeal process to promptly resolve provider billing disputes. The Contractor will cooperate with providers who have exhausted the Contractor's appeal process by entering into arbitration or other alternative dispute resolution process.

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4. Arbitration

When arbitration is requested by a provider, the Contractor is required to participate in a binding arbitration process.

DCH will provide a list of neutral arbitrators that can be made available to resolve billing disputes. These arbitrators will be organizations with the appropriate expertise to analyze medical claims and supporting documentation available from medical record reviews and determine whether a claim is complete, appropriately coded, and should or should not be paid. A model agreement will be developed by DCH that both parties to the dispute will be required to sign. This agreement will specify the name of the arbitrator, the dispute resolution process, a timeframe for the arbitrator's decision, and the method of payment for the arbitrator's fee.

The party found to be at fault will be assessed the cost of the arbitrator. If both parties are at fault, the cost of the arbitration will be apportioned.

The Contractor will be subject to an interest charge based on the value of unpaid claims when clean claims are not processed and paid within 30 days of receipt. Applicable interest rates for the unpaid claims shall be specified by DCH based on Medicare guidelines.

A provider that submits duplicate claims that have previously been denied or returned with notice by the Contractor that the claim is incomplete or incorrect shall be subject to a service charge for each duplicate claim in an amount determined by DCH if the duplicate claim is submitted without completion, correction or further information that addresses denial or return.

5. Post-payment Review

The Contractor may utilize a post-payment review methodology to assure claims have been paid appropriately.

6. Total Payment

The Contractor or its providers may not require any co-payments, patient-pay amounts, or other cost-sharing arrangements unless authorized by DCH. The Contractor's providers may not bill Enrollees for the difference between the provider's charge and the Contractor's payment for Covered Services. The Contractor's providers will not seek nor accept additional or supplemental payment from the Enrollee, his/her family, or representative, in addition to the amount paid by the Contractor even when the Enrollee has signed an agreement to do so.

7. Case Rate Payments for Emergency Services

The Contractor, in the absence of a contract with emergency providers, must provide reimbursement at Medicaid rates for professional and facility services provided in the emergency room of a hospital as required in Section II-I-1 and Section II-1-2 of this Contract. As described in a Medicaid policy bulletin prepared for this issue (Proposed Policy Draft #0034-prac), the DCH will convert the existing

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Medicaid rates to inclusive case rate for professional emergency services provided in a hospital emergency room. The Contractor must use the case rates when presented with claims from emergency providers.

II-O PROVIDER SERVICES (NETWORK AND OUT-OF-NETWORK)

The Contractor will:

- Provide contract and education services for the provider network, ensure proper maintenance of medical records, maintain proper staffing to respond to provider inquiries, and be able to process provider grievances, complaints, and an appeal system to resolve provider billing disputes;
- Maintain a written plan detailing methods of provider recruitment and education regarding Contractor policies and procedures;
- Maintain a regular means of communicating and providing information on changes in policies and procedures to its providers. This may include guidelines for answering written correspondence to providers, offering provider-dedicated phone lines, or a regular provider newsletter;
- Provide a staff of sufficient size to respond timely to provider inquiries, questions and concerns regarding Covered Services.
- Provide a copy of the Contractor's prior authorization policies to the provider when the provider joins the Contractor's provider network. The Contractor must notify providers of any changes to prior authorization policies as changes are made.

II-P QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM STANDARDS

1. Quality Assessment and Performance Improvement Program Standards

The Contractor will have an ongoing Quality Assessment and Performance Improvement Program that meets the requirements of 42 CFR 434.34. The Contractor's medical director shall be responsible for managing the Quality Assessment and Performance Improvement Program. The Contractor must maintain a QIC for purposes of reviewing the Quality Assessment and Performance Improvement Program, its results and activities, and recommending changes on an ongoing basis. The QIC must be comprised of Contractor staff, including but not limited to the quality improvement director and other key management staff, as well as health professionals providing care to Enrollees.

The Contractor's Quality Assessment and Performance Improvement Program will be capable of identifying opportunities to improve the provision of health care services and the outcomes of such care for Enrollees. In addition, the Contractor's Quality Assessment and Performance Improvement Program will incorporate and address findings of site reviews by DCH, external independent reviews, and statewide focused studies and the recommendations of the CAC. In addition, the Contractor's Quality Assessment and Performance Improvement Program must develop or adopt performance improvement goals, objectives and activities or interventions as required by the DCH to improve service delivery or health outcomes for Enrollees.

The Contractor will have a written plan for the Quality Assessment and Performance Improvement Program which includes a statement of the Contractor's performance goals and objectives, lines of authority and accountability including data responsibilities, evaluation tools, and performance improvement activities.

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The written plan must also describe how the Contractor will:

- Analyze both the processes and outcomes of care using currently accepted standards from recognized medical authorities, including focused review of individual cases as appropriate and to discern the causes of variation in the provision of care to Enrollees.

- Establish clinical and non-clinical priority areas and indicators for assessment and performance improvement.

- Use measures to analyze the delivery of services and quality of care, over and under utilization of services, disease management strategies, and outcomes of care. The Contractor is expected to collect and use data from multiple sources such as medical records, encounter data, HEDIS(R), claims processing, grievances, utilization review and member satisfaction instruments in this activity.

- Compare Quality Assessment and Performance Improvement Program findings with past performance and with established program goals and available external standards.

- Measure the performance of Contractor providers and conduct peer review activities such as: identification of practices that do not meet Contractor standards; recommendation of appropriate action to correct deficiencies; and monitoring of corrective action by providers.

- Measure provider performance through the inclusion of medical record audits to be performed at least twice annually on a statistically valid sample of Contractor providers.

- Provide performance feedback to providers, including detailed discussion of clinical standards and expectations of the Contractor.

- Develop and/or adopt clinically appropriate practice parameters and protocols/guidelines and give the Contractor's providers enough information about the protocols to enable them to meet the established standards.

- Evaluate access to care for Enrollees according to the established standards and those developed by the CAC and Contractor's QIC and implement a process for ensuring that network providers meet and maintain the standards. The evaluation should include an analysis of the accessibility of services to Enrollees with disabilities.

- Perform a member satisfaction survey annually, in collaboration with DCH, and distribute results to providers, Enrollees, and DCH.

- Implement improvement strategies related to program findings and evaluate progress periodically but at least annually.

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- Maintain the written plan for the Contractor's Quality Assessment and Performance Improvement Program that will be available to DCH upon request.

2. Performance Objectives

At a minimum, the Contractor will include performance objectives for the delivery of services to Enrollees in the written plan for its Quality Assessment and Performance Improvement Program. The Contractor's performance on these objectives will be monitored by DCH.

For Enrollees with continuous enrollment with the Contractor according to HEDIS(R) reporting standards, the Contractor will be assessed against performance objectives as specified annually by DCH.

DCH will also use the results of performance assessments as part of the formula for automatic enrollment assignments.

The Contractor's QIC may establish additional performance objectives based on its own assessment and program findings.

3. Statewide Performance Improvement

In addition to its internal Quality Assessment and Performance Improvement Program, the Contractor may be required to participate in statewide focused studies or performance improvement activities.

The CAC established by DCH will collaborate with Contractors to determine priority areas for statewide focused studies and performance improvement initiatives. The CAC will establish time frames for submission of data and information for statewide focused studies and will review and approve all analytical methodologies associated with the focused studies to assure that comparisons among Contractors are possible. The clinical priority areas may vary from one year to the next and will reflect the needs of the Beneficiaries. The measures may include, but are not limited to:

- Low birth weight deliveries
- Vaginal delivery and C-section rates
- Well-Child/EPSDT visit periodicity
- Immunization rates
- Re-hospitalization rates
- Mortality rates
- Emergency room use
- Chronic disease prevalence and management.

The Contractor will assess performance for the priority area(s) identified by the CAC as requested by DCH, using defined indicators of health status, functional status, Enrollee satisfaction or valid proxies of these outcomes. The Contractor must submit data and information for priority area(s) as requested by DCH. The Contractor will address the statewide focused study findings for priority area(s) through its Quality Assessment and Performance Improvement Program and develop performance improvement goals, objectives and activities specific to the

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Contractor. The Contractor will incorporate any statewide performance improvement objectives, established as a result of a statewide focus study or performance improvement initiative, into the written plan for its Quality Assessment and Performance Improvement Program.

The CAC may recommend standards of care and related protocols in areas including, but not limited to: family planning, diabetes, asthma, end stage renal disease, AIDS, and maternal and infant support. The Contractor must implement these standards of care and related protocols through its Quality Assessment and Performance Improvement Program if required by DCH.

4. External Quality Review

The State will arrange for an annual, external independent review of the quality and outcomes, timeliness of, and access to Covered Services provided by the Contractor. The Contractor will address the findings of the external review through its Quality Assessment and Performance Improvement Program. The Contractor must develop and implement performance improvement goals, objectives and activities in response to the external review findings as part of the Contractor's Quality Assessment and Performance Improvement Program. A description of the performance improvement goals, objectives and activities developed and implemented in response to the external review findings will be included in the Contractor's quality assessment and performance improvement program and provided to DCH upon request. DCH may also require separate submission of an improvement plan specific to the findings of the external review.

5. Annual Effectiveness Review

The Contractor will annually conduct an effectiveness review of its Quality Assessment and Performance Improvement Program. The effectiveness review must include analysis of whether there have been improvements in the quality of health care and services for Enrollees as a result of quality assessment and improvement activities and interventions carried out by the Contractor. The analysis should take into consideration trends in service delivery and health outcomes over time and include monitoring of progress on performance goals and objectives. Information on the effectiveness of the Contractor's Quality Assessment and Performance Improvement Program must be provided annually to network providers and to Enrollees upon request. Information on the effectiveness of the Contractor's Quality Assessment and Performance Improvement Program must be provided to DCH upon request.

6. Consumer Survey.

Contractors must conduct a survey of their enrollee population using the Consumer Assessment of Health Plan Survey, CAHPS, instrument either by partnering with the DCH through cost sharing or by directly contracting with a NCQA certified CAHPS vendor and submitting the data according to the specifications and timelines established by the DCH.

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II-Q UTILIZATION MANAGEMENT

The major components of the Contractor's utilization management plan must encompass, at a minimum, the following:

- Written policies and procedures that conform with managed health care industry standards and processes.
- A formal utilization review committee directed by the Contractor's medical director to oversee the utilization review process.
- Sufficient resources to regularly review the effectiveness of the utilization review process, and to make changes to the process as needed.
- An annual review and reporting of utilization review activities and outcomes/interventions from same.

The Contractor may establish and use a prior approval procedure for utilization management purposes provided that it does not use such procedures to avoid providing medically necessary services within the coverages established under the Contract. The utilization management activities of the Contractor must be integrated with the Contractor's quality assessment and performance improvement program.

II-R THIRD PARTY RESOURCE REQUIREMENTS

The Contractor will collect any payments available from other health insurers including Medicare and private health insurance for services provided to its members in accordance with Section 1902(a)(25) of the Social Security Act and 42 CFR 433 Subpart D. The Contractor will be responsible for identifying and collecting third party liability information and may retain third party collections.

Third party liability (TPL) refers to any other health insurance plan or carrier (e.g., individual, group, employer-related, self-insured or self-funded plan or commercial carrier, automobile insurance and worker's compensation) or program (e.g., Medicare) that has liability for all or part of a member's health care coverage. Contractors are payers of last resort and will be required to identify and seek recovery from all other liable third parties in order to make themselves whole. All such collections may be retained by the Contractor. The Contractor must report third party collections in its encounter data submission and in aggregate as required by DCH.

DCH will provide the Contractor with a listing of known third party resources for its Enrollees. The listing will be produced monthly and will contain information made available to the State at the time of eligibility determination and/or redetermination.

When an Enrollee is also enrolled in Medicare, Medicare will be the primary payer ahead of any Contractor. The Contractor must make the Enrollee whole by paying or otherwise covering all Medicare cost sharing amounts incurred by the Enrollee such as coinsurance and deductibles.

II-S MARKETING

With the approval of DCH, Contractors are allowed to promote their services to the general population in the community, provided that such promotion and distribution of materials is directed at the population of the entire approved service area.

However, direct marketing to individual Beneficiaries is prohibited. The Contractor may not provide inducements through which compensation, reward, or supplementary benefits or services are offered to Beneficiaries to enroll or to remain enrolled with the

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Contractor. DCH will review and approve any form of marketing. The following are examples of allowed and prohibited marketing locations and practices:

1. Allowed Marketing Locations/Practices directed at the general population:

   - Newspaper articles
   - Newspaper advertisements
   - Magazine advertisements
   - Signs
   - Billboards
   - Pamphlets
   - Brochures
   - Radio advertisements
   - Television advertisements
   - Noncapitated plan sponsored events
   - Public transportation (i.e. buses, taxicabs)
   - Mailings to the general population.

2. Prohibited Marketing Locations/Practices which target individual Beneficiaries:

   - Local FIA offices
   - Provider offices
   - Individual Contractor "Health Fairs"
   - Malls or commercial retail establishments
   - Hospitals
   - Check cashing establishments
   - Door-to-door marketing
   - Telemarketing
   - Community centers and clinics
   - Churches
   - Direct mail targeting individual Medicaid Beneficiaries
   - WIC clinics.

3. Marketing Materials

   The Contractor is required to develop informational materials such as pamphlets and brochures that can be used to assist Beneficiaries in choosing a Contractor. Marketing materials shall contain provider and physician choices offered by the Contractor, and their locations and specialties. All written and oral materials must be prior approved by DCH.

   Materials must be written at no higher than 6th grade level as determined by any one of the following indices:

   - Fry Readability Index
   - PROSE The Readability Analyst (software developed by Educational Activities, Inc.)
   - Gunning FOG Index
   - McLaughlin SMOG Index
   - Other computer generated readability indices accepted by DCH.

   Marketing materials must be available in languages appropriate to the Beneficiaries being served within the county. All material must be culturally appropriate and available in alternative formats in accordance with the American with Disabilities Act.

   DCH may impose monetary or restricted enrollment penalties should the Contractor or any of its subcontractors or providers be found to use marketing materials which have not been approved in writing by DCH or engage in prohibited marketing practices. DCH reserves the right to suspend all enrollment of new Enrollees into

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the Contractor's plan. Such suspensions may be imposed for a period of sixty (60) days from notification of the violation by DCH to the Contractor.

II-T MEMBER AND ENROLLEE SERVICES

1. General

All Enrollee services must address the need for culturally-appropriate interventions. Reasonable accommodation must be made for Enrollees with hearing and/or vision impairments.

Contractors will establish and maintain a toll-free 24 hours a day, 7 days a week telephone number to assist with questions that Enrollees may have about the Contractor's providers or Covered Services.

Contractors will issue an eligibility card to all Enrollees that identifies their PCP's name and phone number. The card must also include the tollfree 24 hours a day, 7 days a week phone number for Enrollees to call and a unique identifying number for the Enrollee.

The Contractor will demonstrate a commitment to case managing the complex health care needs of Enrollees. That commitment will be demonstrated by the involvement of the Enrollee in the development of his or her treatment plan and will take into account all of an Enrollee's needs (e.g. home health services, therapies, durable medical equipment and transportation).

Contractors will accept as enrolled all Enrollees appearing on monthly enrollment reports and infants enrolled by virtue of the mother's enrollment status. Contractors may not discriminate against Beneficiaries on the basis of health needs or health status.

The duties of each Contractor include arrangements for medically necessary services and education of Enrollees with regard to the importance of preventive care. In this context, Contractors may not encourage an Enrollee to disenroll because of health care needs or a change in health care status. Further, an Enrollee's health care utilization patterns may not serve as the basis for disenrollment from the Contractor. Subject to the above, Contractors may request that DCH prospectively disenroll an Enrollee for cause and present all relevant evidence to assist DCH in reaching its decision. DCH shall consider all relevant factors in making its decision. DCH's decision regarding disenrollment shall be final. Disenrollments "for cause" will be the first day of the next available month.

2. Enrollee Education

(a) The Contractor will be responsible for developing and maintaining Enrollee education programs designed to provide the Enrollee with clear, concise, and accurate information about the Contractor's services. Materials for Enrollee education should include:

- Member handbook
- Contractor bulletins or newsletters sent to the Contractor's Enrollees at least three times a year that provide updates related to Covered Services, access to providers and updated policies and procedures.
- Literature regarding health/wellness promotion programs offered by the Contractor.

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(b) Enrollee education should also focus on the appropriate use of health services. Contractors are encouraged to work with local and community based organizations to facilitate their provision of Enrollee education services.

3. Member Handbook/Provider Directory

Contractors must mail printed information via first class mail on accessing Covered Services to all Enrollees within five (5) Business Days of being notified of their enrollment. When there are program or service site changes, notification must be provided to the affected Enrollees at least ten (10) Business Days before implementation.

The Contractor must maintain documentation verifying that the information in the member handbook is reviewed for accuracy and updated at least once a year. The provider directory may be published separately. At a minimum the member handbook must include:

- A table of contents
- A Provider Directory listed by county including:
  Provider name, address, telephone number and any hospital affiliation
  Days and hours of operation
  Languages spoken at the primary care sites
  Information on how to choose and change PCPs
- A list of all hospitals, pharmacies, medical suppliers, and other ancillary health providers the Enrollees may need to access
- What to do when family size changes
- How to make, change, and cancel appointments with a PCP
- A description of all available Contract services and an explanation of any service limitations or exclusions from coverage
- How to contact the Contractor's Member Services and a description of its function
- Information regarding the grievance and complaint process including how to register a complaint with the Contractor, and/or the State, and how to file a written grievance
- Information regarding the State's fair hearing process and that access to that process may occur without first going through the Contractor's grievance/complaint process
- What to do in case of an emergency and instructions for receiving advice on getting care in case of any emergency. Enrollees should be instructed to activate emergency medical services (EMS) by calling 9-1-1 in life threatening situations
- How to obtain emergency transportation and medically necessary transportation
- How to obtain medically necessary durable medical equipment (or customized durable medical equipment)
- How to access hospice services
- Information on the signs of substance abuse problems, available substance abuse services and accessing substance abuse services
- Information on well-child care, immunizations, and follow-up services for Enrollees under age 21 (EPSDT)
- Information on vision services, family planning services, and how to access these services
- Information on the process of referral to specialists and other providers
- Information on the availability and process for accessing Covered Services that are not the responsibility of the Contractor, but are available to its Enrollees such as dental care, behavioral health and developmental disability services
- Information on how to handle out of county and out of state services
- Information to Enrollees that they are entitled to receive FQHC services
- How Enrollees can contribute towards their own health by taking responsibility, including appropriate and inappropriate behavior

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- Information regarding pregnancies which conveys the importance of prenatal care and continuity of care, to promote optimum care for mother and infant
- Information regarding the Women's, Infant's, and Children (WIC) Supplemental Food and Nutrition Program
- Information advising Enrollees of their right to request information regarding physician incentive arrangements including those that cover referral services that place the physician at significant financial risk (more than 25%), other types of incentive arrangements, whether stop-loss coverage is provided
- Information regarding when specialists may be designated as their PCP; and
- Any other information deemed essential by the Contractor and/or the DCH
- Information regarding the Enrollee's right to obtain routine OB/GYN and Pediatric services from network providers without a referral.

The handbook must be written at no higher than a sixth grade reading level. Member handbooks must be available in languages other than English when more than five percent (5%) of the Contractor's Enrollees speak another language. The Contractor must submit all member handbook material to DCH for approval prior to distribution to members. The Contractor must agree to make modifications in the handbook language so as to comply with the specifications of this Contract.

4. Protection of Enrollees Against Liability for Payment and Balanced Billing

Section 1932(b)(6) of the Social Security Act requires Contractors to protect Enrollees from certain payment liabilities. Section 1128B(d)(1) of the Social Security Act authorizes criminal penalties to providers in the case of services provided to an individual enrolled with a Contractor which are charges at a rate in excess of the rate permitted under the organization's Contract.

II-U GRIEVANCE/COMPLAINT PROCEDURES

The Contractor will establish and maintain an internal process for the resolution of complaints and grievances from Enrollees. Enrollees may file a complaint or grievance on any aspect of service provided to them by the Contractor.

Enrollees must be told of their right to an administrative hearing if dissatisfaction is expressed at any point during the rendering of medical treatment. While Contractors may attempt to resolve the dispute through their grievance or complaint process, this process must not supplant or replace the Enrollee's right to file a hearing request with DCH. The Contractor's grievance or complaint process may occur simultaneously with DCH's administrative hearing process.

The following definitions apply:

DCH Administrative Hearing: Also called a fair hearing, an impartial review by DCH of a decision made by the Contractor that the Enrollee believes is inappropriate. The Administrative Hearing is conducted by an Administrative Law Judge.

Administrative Law Judge: A person designated by DCH to conduct the Administrative Hearing in an impartial or unbiased manner.

Adverse Determination: A determination by a Contractor that a facility admission, availability of care, continued stay or other health care service has been reviewed

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and denied, reduced or terminated. Failure of the Contractor to respond in a timely manner constitutes an adverse determination.

Complaint: A communication by an Enrollee or an Enrollee's representative to the Contractor expressing an opinion about care or service provided by the Contractor, or presenting an issue to the Contractor with a request for relief that can be resolved informally. Complaints may be oral or written.

Grievance: A written complaint on behalf of an Enrollee, submitted by an Enrollee or a person, including but not limited to, a physician authorized to act on behalf of the Enrollee regarding:

(a) availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review;
(b) claims payment, handling or reimbursement for health care services;
(c) matters pertaining to the contractual relationship between a Contractor and an Enrollee.

1. Contractor Grievance/Complaint Procedure Requirements

The Contractor agrees to have written policies and procedures governing the resolution of complaints and grievances. These written policies and procedures will meet the following requirements:

- The Contractor shall administer an internal complaint and grievance procedure according to the requirements of MCLA 500.22113 and shall cooperate with the Michigan Office of Financial and Insurance Services in the implementation of 2000 PA 251, "Patient's Rights to Independent Review Act".

2. Notice to Enrollees of Grievance Procedure

The Contractor will inform Enrollees about the Contractor's internal grievance procedures at the time of initial enrollment, each time a service is denied, reduced or terminated, and any other time a Enrollee expresses dissatisfaction with the Contractor. The information will be included in the member handbook and will explain:

- how to file a complaint or grievance with the Contractor
- the internal grievance resolution process
- the member's right to a fair hearing with the State

3. State Medicaid Appeal Process

The State will maintain a Medicaid fair hearing process to ensure that Enrollees have the opportunity to appeal decisions directly to the State.

4. Termination of Coverage

(a) The Contractor shall be responsible for the Enrollee's medical care until the Department notifies the Contractor that its responsibility for the Enrollee is no longer in effect.

(b) DCH will not retroactively disenroll any Enrollees unless the person was enrolled in error, the person died before the beginning of the month in which a capitation payment was made, or for CSHCS enrollment as described under (c) (v) below. Recoupments of capitation will be collected by DCH for all retroactive

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disenrollments. DCH shall only retroactively enroll newborns and persons previously enrolled who regain eligibility for Medicaid within ninety-three (93) days from the date eligibility was lost. The Contractor shall not deny payment for medically necessary covered services provided during the 93 day re-enrollment period for reason of not authorized.

(c) Coverage for an Enrollee shall terminate whenever any of the following occurs:

i. This Contract is terminated for any reason.

ii. The Enrollee is no longer eligible for Medicaid and does not regain eligibility within ninety-three (93) days.

iii. The Enrollee dies. The Contractor shall be entitled to a capitation payment for such person through the last day of the month in which death occurred.

iv. The Enrollee moves outside the Contractor's service area. In such instances, the Enrollee shall be disenrolled effective the first (1st) day of the month following DCH's implementation of the change of address. The Contractor shall remain responsible for all medically necessary Covered Services until the effective date of disenrollment.

v. The Enrollee is medically eligible for CSHCS and has elected to enroll in CSHCS. When the Enrollee has joined CSHCS, the Enrollee will be disenrolled from the Contractor's health plan effective with the first day of the month for which CSHCS medical eligibility was determined. The Contractor will assist DCH in determining medical eligibility by promptly providing medical documentation to DCH using standard forms and will also assist the DCH in CSHCS enrollment education efforts after medical eligibility has been confirmed.

vi. The Enrollee is eligible for long-term custodial services in a nursing facility following discharge from an acute care inpatient facility.

- The Contractor shall involve DCH in discharge planning for Enrollees whom the Contractor believes will require custodial long-term care services in a nursing facility upon discharge from the inpatient setting. If DCH is involved and if DCH agrees that the Enrollee meets the criteria for admission to a nursing facility for long-term custodial care upon discharge from the inpatient setting, DCH will disenroll the Enrollee from the Contractor's plan upon discharge from the inpatient setting.
- If the Contractor fails to provide DCH with sufficient notice of the impending discharge or does not include DCH in discharge planning for the Enrollee, the Contractor will be responsible for all services required by the Enrollee for up to 45 days.
- The Contractor is responsible for all restorative and rehabilitative services required by its Enrollees (including care in a nursing facility). The Contractor is not responsible for

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Covered Services provided in a nursing facility that was not authorized by the Contractor.

. DCH has sole responsibility for the determination of eligibility for long-term care services paid for by DCH.

vii. The Enrollee is admitted to a state psychiatric hospital. An Enrollee admitted to a state psychiatric hospital shall be disenrolled at the end of the month. The Contractor shall not be responsible for reimbursing the state psychiatric hospital.

viii. The Enrollee is granted a disenrollment by DCH for medical exceptions.

(a) Except for Beneficiaries who may be medically eligible for CSHCS, the Contractor shall not ask DCH to disenroll an Enrollee because of an adverse change in the Enrollee's health. The Contractor must ensure DCH that any request for termination is not due to a change in the Enrollee's health.

(b) The Contractor may terminate the enrollment of an Enrollee, subject to the prior approval of DCH, when actions by the Enrollee are inconsistent with Contractor's membership, including fraud, abuse of the Contractor's services, or other intentional misconduct; or if, in the opinion of the PCP, the Enrollee's behavior make its medically infeasible to safely or prudently render Covered Services. Such termination is subject to the grievance procedures as set forth in this section of the Contract. The notice of termination shall be immediately communicated to the Enrollee whose enrollment is terminated, along with procedures for expeditious review pursuant to Section (II-U1).

The Contractor may require an Enrollee to sign a statement agreeing to use only the Contractor's providers for obtaining health care. The Contractor shall advise the Enrollee that to abuse this requirement by willfully and knowingly obtaining Covered Services from out-of-network providers or providers not otherwise authorized to provide services under the Contractor may result in enrollment termination. The Contractor must obtain DCH approval prior to the implementation of such an agreement.

(c) The Contractor agrees to accept automatic reinstatement of a person previously enrolled who regains eligibility for Medicaid with ninety-three (93) days from the date eligibility was lost. The Contractor assumes responsibility for services provided during this ninety-three (93) day period for any month the beneficiary gains Medicaid eligibility.

(d) The Contractor shall remain liable for all Covered Services until the date of the Enrollee's termination of coverage becomes effective.

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(e) DCH will terminate enrollment in order to implement the decision of an Administrative Law Judge resulting from a formal grievance proceeding.

Nothing in this paragraph or this Contract shall be construed to limit or in any way jeopardize a Beneficiary's Medicaid eligibility.

II-V CONTRACTOR ON-SITE REVIEWS

Contractor on-site reviews by DCH will be an ongoing activity conducted during the Contract. The Contractor's on-site review may include the following areas: administrative, financial, provider, Covered Services, quality assurance, utilization review, data reporting, claims processing, and documentation. These reviews will present an opportunity for the State to physically inspect provider offices for accessibility.

II-W CONTRACT REMEDIES

The State will utilize a variety of means to assure compliance with Contract requirements. The State will pursue remedial actions or improvement plans that the Contractor can implement to resolve outstanding requirements. If remedial action or improvement plans are not appropriate or are not successful, Contract remedies including, but not limited to, enrollment freezes, capitation withholding, or other financial penalties will be implemented. CHCP requirements that are subject to the implementation of remedies include but are not limited to:

- immunization target rates
- Well Child/EPSDT target rates
- marketing
- member services
- enrollment practices
- provider network requirements
- provider payments
- financial requirements
- data submission
- data reporting
- data validity
- Enrollee access
- Enrollee satisfaction.

The application of remedies will be a matter of public record.

The use of intermediate sanctions for non-compliance is described in Section 1932(e) of the Social Security Act as enacted in the Balanced Budget Act section 4707(e). This provision states that a hearing must be afforded to Contractors before termination of a Contract under this section can occur. The State must notify Enrollees of such a hearing and allow Enrollees to disenroll, without cause, if they choose.

In addition to the general remedies described above:

1) DCH will administer contract remedies to assure the prompt and timely reporting required under this Contract. Remedies will be as follows:

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- If a report required under this Contract is not submitted on or before the required date the Contractor will have its enrollment frozen. If the required reporting is more than 10 business days late the Contractor will have 10% of its capitation withheld. Contractors will have the enrollment unfrozen and the withheld capitation paid the next available month following receipt of the required reports.

2) DCH will administer Contract remedies to assure compliance with the payment to provider requirements contained in Section II-N of this Contract. Remedies will be as follows:

   - If DCH determines that Contractor is not in compliance with either the electronic billing capacity timelines as required in Section II-N-1 or if the Contractor is not complying with the prompt payment standards as required in Section II-N-2 the Contractor will have 10% of its capitation withheld. This determination will be made through DCH site assessments and findings and/or review of the monthly claims lag reporting. Withheld capitation will be paid the next available month following compliance with the respective requirements.

3) DCH will also administer and enforce a monetary penalty of not more than $5000.00 to a contractor for repeated failures on any of the findings of DCH site visit report. Collections under this Contract remedy will be through gross adjustments to the monthly payments described in Section I-J of this Contract and will be allocated to the fund established under Section II-AA-e of the Contract for performance bonus.

II-X DATA REPORTING

To measure the Contractor's accomplishments in the areas of access to care, utilization, medical outcomes, Enrollee satisfaction, and to provide sufficient information to track expenditures and calculate future Capitation Rates the Contractor must provide the DCH with uniform data and information as specified by DCH. The Contractor must submit an annual consolidated report using the instructions and format covered in Contract Appendix E. In addition to the annual consolidated report, the Contractor must submit monthly and quarterly reports as specified in this section. Any changes in the reporting requirements will be communicated to the Contractor at least ninety (90) days before they are effective unless state or federal law requires otherwise.

The Contractor's timeliness in submitting required reports and their accuracy will be monitored by DCH and will be considered by DCH in ranking the performance of the Contractor.

The Contractor must cooperate with DCH in carrying out validation of data provided by the Contractor by making available medical records and a sample of its data and data collection protocols. The Contractor must develop and implement corrective action plans to correct data validity problems as identified by the DCH.

The following information and reports must be submitted to the Department in addition to the annual consolidated report:

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1. HEDIS(R)

The Contractor annually submit Michigan specific HEDIS reports according to the most current NCQA specifications and timelines, utilizing Michigan specific samples of Enrollees. The Contractor must contract with a NCQA certified HEDIS auditing vendor and undergo a full audit of their HEDIS reporting process.

2. Encounter Data Reporting

In order to assess quality of care, determine utilization patterns and access to care for various health care services, affirm Capitation Rate calculations and estimates, the Contractor will submit encounter data containing detail for each patient encounter reflecting all services provided by the Contractor. Encounter records will be submitted monthly via electronic media in the format specified by DCH. Encounter level records must have a common identifier that will allow linkage between DCH's and the Contractor's Management Information Systems.

The Contractor must submit quarterly utilization reports within 30 days after the end of the reporting quarter, until DCH determines that comparable, accurate data is available through the encounter data system. Quarterly utilization reports must provide data as specified by DCH. Contractor will be notified by DCH when the requirement for quarterly utilization reports is eliminated.

3. Financial and Claims Reporting Requirements

In addition to meeting all HMO financial reporting requirements and providing copies of the HMO financial reports to DCH, Contractors must provide to DCH monthly statements that provide information regarding paid claims, aging of unpaid claims, and denied claims. The DCH may also require monthly financial statements from Contractors.

4. Quality Assessment and Performance Improvement Program Reporting

The Contractor must perform and document annual assessments of their quality assessment and performance improvement program. This assessment is to summarize any modifications made in the quality assessment and performance improvement program, a description of performance improvement activities for the previous year, an effectiveness review (including progress on performance goals and objectives), and a work plan for the coming year. The assessment must also include results of the Contractor's member satisfaction survey if the Contractor does not participate with DCH coordinated survey activity. The Contractor may be required to provide this assessment and other reports or improvement plans addressing specific contract performance issues identified through site visit reviews, external independent reviews, focused studies or other monitoring activities conducted by DCH.

II-Y RELEASE OF REPORT DATA

The Contractor must obtain DCH's written approval prior to publishing or making formal public presentations of statistical or analytical material based on its Enrollees.

[GRAPHIC APPEARS HERE]

II-Z MEDICAL RECORDS

The Contractor must ensure that its providers maintain medical records of all medical services received by the Enrollee. The medical record must include, at a minimum, a record of outpatient and emergency care, specialist referrals, ancillary care, diagnostic test findings including all laboratory and radiology, prescriptions for medications, inpatient discharge summaries, histories and physicals, immunization records, other documentation sufficient to fully disclose the quantity, quality, appropriateness, and timeliness of services provided.

1. Medical Record Maintenance

The Contractor's medical records must be maintained in a detailed and comprehensive manner which conforms to good professional medical practice, permits effective professional medical review and medical audit processes, and which facilitates an adequate system for follow-up treatment. Medical records must be signed and dated. All medical records must be retained for at least six (6) years.

The Contractor must have written policies and procedures for the maintenance of medical records so that those records are documented accurately and in a timely manner, are readily accessible, and permit prompt and systematic retrieval of information. The Contractor must have written plans for providing training and evaluating providers' compliance with the recognized medical records standards.

2. Medical Record Confidentiality/Access

The Contractor must have written policies and procedures to maintain the confidentiality of all medical records. DCH and/or HCFA shall be afforded prompt access to all Enrollees' medical records. Neither HCFA nor DCH are required to obtain written approval from an Enrollee before requesting an Enrollee's medical record. When an Enrollee changes PCP, his or her medical records or copies of medical records must be forwarded to the new PCP within ten (10) working days from receipt of a written request by the former PCP.

II-AA SPECIAL PAYMENT PROVISIONS

1. DCH processing Inpatient Claims

The Contractor may elect an option whereby the Contractor's inpatient claims will be paid from an account established through the withholding of the hospital portion of the Contractor's Capitation Rate. Hospital claims will be paid at Medicaid rates and will not include payments for graduate medical education and regular disproportionate share hospital payments. The Contractor will be required to authorize all non-emergent hospital services before they are paid by DCH. At the end of each year of the Contract an interim settlement of the account will be made. A final settlement will be made twelve months after each interim settlement. An administrative fee may be charged by DCH for this function. At the time the interim settlement is made, the Contractor will be paid 50% of any amount remaining in the account for the year being settled. When the final settlement of the account is made for each year, the Contractor will be paid any amount remaining in the account for the settled year. If the account has a negative balance at any time, the Contractor will be required to pay into the account to eliminate the negative balance and future withholding may be increased to ensure that the account is properly funded.

2. Payment of Rural Access Incentive

In addition to the capitation payment agreed to and included in the Contract as Attachment A, the DCH will provide an additional "add-on" payment for health plans who have been approved to provide services in any or all of the following counties:

[GRAPHIC APPEARS HERE]

- Alcona, Alpena, Antrim, Benzie, Charlevoix, Cheboygan, Clare, Crawford, Emmet, Gladwin, Huron, Kalkaska, Leelanau, Mason, Mecosta, Midland, Missaukee, Montmorency, Oceana, Osceola, Otsego, Presque Isle, Sanilac, Tuscola, and Wexford.

Payment will be provided each month in the form of an additional $3 dollars/per member/per month payment for each Beneficiary enrolled with the Contractor. Five ($5) dollars per member per month will be paid to the Contractor if the Contractor is serving all of the above listed counties. It is expected that the additional payment will be used to help support the provider and infrastructure costs for operating a managed care plan in a rural environment. Contractors will be required to report on the disposition, of the payments received through this additional reimbursement.

3. Contractor Performance Bonus

During each Contract year, the DCH will withhold .0025 of the approved capitation for each Contractor. The amount withheld will be used to establish a fund for awarding Contractor performance bonus payments. These payments will be made to those high performing Contractors according to criteria established by DCH. The criteria will include assessment of performance in quality, of care, beneficiary responsiveness, and administrative functions. The DCH will establish the criteria and measurement of the criteria at the start of each fiscal year and provide notice to each Contractor.

II-BB RESPONSIBILITIES OF THE DEPARTMENT OF COMMUNITY HEALTH

DCH will be responsible for administering the CHCP. It will administer Contracts with Contractors, monitor Contract performance, and perform the following activities:

- Pay to the Contractor a PMPM Capitation Rate as agreed to in the Contract for each Enrollee.
- Determine eligibility for the Medicaid program and determine which Beneficiaries will be enrolled.
- Determine if and when an Enrollee will be disenrolled from the Contractor's plan or changed to another Medicaid managed care program.
- Notify the Contractor of changes in enrollment.
- Notify the Contractor of the Enrollee's name, address, and telephone number if available. The Contractor will be notified of changes as they are known to the DCH.
- Issue Medicaid identification cards to Enrollees that include the name and phone number of the Enrollee's Contractor.
- Provide the Contractor with information related to known third party resources and any subsequent changes and be responsible for reporting paternity related expenses to FIA.
- Notify the Contractor of changes in Covered Services or conditions of providing Covered Services.
- Maintain a CAC to collaborate with Contractors on quality improvement.
- Protect against fraud and abuse involving Medicaid funds and Enrollees in cooperation with appropriate state and federal authorities.
- Administer a Medicaid fair hearing process consistent with federal requirements.
- Collaborate with the Contractor on quality improvement activities, fraud and abuse issues, and other activities which impact on the health care provided to Enrollees.
- Conduct a member satisfaction survey of all Enrollees, compile, and publish the results.
- Review and approve Contractor marketing and member information materials before being released to Enrollees.
- Apply Contract remedies as necessary to assure compliance with Contract requirements.

[GRAPHIC APPEARS HERE]

- Monitor the operation of the Contractor to ensure access to quality care for Enrollees.

II-CC RESPONSIBILITIES OF THE DEPARTMENT OF ATTORNEY GENERAL

The Health Care Fraud Division of the Department of Attorney General (Medicaid Fraud Control Unit) is the State agency responsible for the investigation of fraud in the State Medicaid program. Contractors shall immediately report to the Michigan Medicaid Fraud Control Unit any suspicion or knowledge of fraud, including but not limited to the false or fraudulent filings of claims and/or the acceptance or failure to return monies allowed or paid on claims known to be false or fraudulent. The reporting entity shall not attempt to investigate or resolve the reported suspicion, knowledge or action without informing the Michigan Medicaid Fraud Control Unit and must cooperate fully in any investigation by the Fraud Control Unit and any subsequent legal action that may result from such investigation.

Contractors and their health care providers participating in the State Medicaid program shall, upon request, make available to the Medicaid Fraud Control Unit any and all administrative, financial and medical records relating to the delivery of items or services for which State Medicaid program funds are expended. In addition, the Medicaid Fraud Control Unit must be allowed access to the place of business and to all records of any managed care organization or health care providers or any sub-contractors during normal business hours, except under special circumstances when after-hour admission shall be allowed. Special circumstances shall be determined by the Medicaid Fraud Control Unit.

[GRAPHIC APPEARS HERE]

SECTION III

CONTRACTOR INFORMATION

III-A BUSINESS ORGANIZATION

Molina Healthcare of Michigan, Inc.
dba Molina Healthcare of Michigan
43097 Woodward Avenue, Suite 200
Bloomfield Hills, MI 48302

III-B AUTHORIZED CONTRACTOR EXPEDITER

Michael A. Graham, CEO
Phone: (248)454-1070
Fax: (248)454-1080

APPENDICES

A. Model local agreement with local health departments and matrix for coordination of services

B. Model local agreement with behavioral health provider.

C. Model local agreement with developmental disability provider.

D. Provider network format and ancillary provider format for service area expansion.

E. Annual Consolidated Report.

F. Schedule for reporting requirements for Contractors.

APPENDIX A

Model Agreement Between HEALTH PLAN and Local Health Department (LHDs)

Model Agreement Between HEALTH PLAN and Local Health Department (LHDs)

The agreements between the Qualified Health Plan and the local health department (LHD) must incorporate and address all of the items and areas listed and described below. These standard provisions are as follows:

- Legal Basis
- Term of Agreement
- Administration
- Areas of Coordination and Collaboration
- Reporting Requirements
- Indemnification
- Governing Laws

This agreement is made and entered into this______day of_______,20__by and between________________and________________________.
(Health Plan) (LHD)

(1) Legal Basis

Whereas, P.A. 352 of the Public Acts of 1996 permits the Department of Community Health to increase the enrollment of Medicaid eligible persons in qualified health plans on a capitated basis; and

Whereas, in order to expand enrollment the Department of Community Health has established a competitive bid process that has resulted in contracts with health plans that are deemed to be qualified to provide specified health care services to Medicaid enrollees; and

Whereas, the Michigan Public Health Code, Act 368 of 1978, as amended, places responsibility with local health departments to prevent disease, prolong life, and promote the public health through organized programs, including prevention and control of environmental health hazards, prevention and control of diseases, prevention and control of particularly vulnerable population groups, development of health care facilities and health services delivery systems, and regulation of health care facilities and health services delivery systems to the extent provided by law; and

Whereas, qualified health plans and LHDs should coordinate and collaborate efforts in order to promote and protect the health of Medicaid enrolled population;

Now, therefore the Qualified Health Plan and the LHD agree as follows:

(2) Term of Agreement

This agreement will be effective______________20____for a period not to exceed_____________. The agreement will be subject to amendment due to changes in the contracts between the Department of Community Health and the Qualified Health Plan.

Upon signed agreement of both parties, the provisions of this agreement will be extended for a time frame consistent with the contract period of the Qualified Health Plan and the Department of Community Health. Either party may cancel the agreement upon 30 day written notice.

(3) Administration and Point of Authority

The Qualified Health Plan shall designate in writing to the LHD the person who has authority to administer this agreement. The LHD shall designate in writing to the Qualified Health Plan the person who has authority to administer this agreement.

(4) Areas of Coordination and Collaboration

Under the contract with the Department of Community Health, Qualified Health Plans are responsible and accountable for providing or arranging health services specified within the contract. As identified in the accompanying matrix, certain health care services may be more efficiently and effectively delivered through coordination and collaboration with LHDs. The matrix describes opportunities for coordination and collaboration for the following services:

- (a) Communicable Diseases
  - HIV/AIDS
  - STDs
  - Tuberculosis
  - Immunizations
- (b) Chronic Diseases
  - Breast and Cervical Cancer
  - Diabetes
  - Cardiovascular Diseases
- (c) Family Planning
- (d) Prenatal and Postnatal care
- (e) Maternal and Infant Support Services
- (f) Laboratory
- (g) Lead (Pb)
- (h) Well Child Care (EPSDT)

The intent of this agreement is to explicitly describe the services to be coordinated and the essential aspects of collaboration between the qualified health plan and the LHD using the matrix as a guide. The agreement may also include provisions for the LHD serving as a direct provider of services for the qualified health plan and related reimbursement arrangements. The LHD will look solely to the health plan for reimbursement regarding direct care services provided to the plan's Medicaid enrollees.

(5) Reporting Requirements

Health care providers, including qualified health plans and its provider panel, are required to report communicable diseases and certain other conditions to LHDs. This requirement is included in PA 368 of 1978, the Public Health Code.

(6) Indemnification

Both parties will agree to provisions that protect against liability in the performance of activities related to this agreement.

(7) Governing Laws

Both parties agree that performance under this agreement will be conducted in compliance with all federal, state, and local laws, regulations, guidelines and directives.

SIGNATURE
Approved as to form by local Counsel.

COORDINATION AND COLLABORATION BETWEEN HEALTH PLANS AND PUBLIC HEALTH AGENCIES
ON SELECTED SERVICES

NO.	HEALTH PLAN SERVICES	COORDINATION AND COLLABORATION ROLES: HEALTH PLAN	LOCAL HEALTH DEPARTMENT (LHD)	MICHIGAN DEPARTMENT OF COMMUNITY HEALTH (MDCH)
1.	COMMUNICABLE DISEASES Screening, diagnosis, and treatment, including screening and risk assessment for at risk populations, e.g., substance abusers Complete case and laboratory reporting to LHD and MDCH Provide for specimen or isolate collection and transportation to MDCH laboratory, for testing to support outbreak investigation and surveillance studies (including but not limited to all Salmonella, Shigella and E.coli O 157:H7 Isolates) Cooperate with LHD and MDCH in outbreak Investigation and disease surveillance studies STANDARD: Michigan Administrative Code Disease Control Rules	Collaborate with LHD to develop and implement protocols based on standardized guidelines to provide, authorize or contract for adequate screening, testing, diagnosis, isolation, and treatment of enrollees exposed to or infected with communicable diseases	Notification of individuals who may have been exposed to a communicable disease Lead outbreak investigations Provide local disease surveillance	Support and assist in outbreak investigations Assure availability of vaccines not specific to childhood immunization Provide state wide population based disease surveillance Develop and implement state-wide surveillance studies Perform reference and epidemiological testing to support outbreak investigation and surveillance studies (including but not limited to all Salmonella, Shigella and E.coli O 157:H7 Isolates) Provide assistance organizing and maintaining surveillance and reporting systems
	a) HIV/AIDS b) STD Screen to identify high risk enrollees seen for prenatal, family planning, substance abuse, tuberculosis and emergency services and for high risk patients seen through other plan services Provide, authorize or contract for adequate counseling, testing, diagnosis and treatment according to state and federal guidelines Provide disease and prevention education to all high risk enrollees Assure complete HIV and STD case and STD laboratory reporting Perform, or refer to LHD, for partner notification services	Where the health plan is directly providing HIV counseling and testing, and/or STD testing, collaborate with LHD and MDCH in use of protocols and confidentiality provisions, Including access to services for minors Participate where appropriate in regional HIV prevention and care planning	LHD may provide HIV counseling and testing, and/or STD testing Where the health plan is directly providing HIV counseling and testing, and/or STD testing, the LHD can provide: protocols for HIV and STD screening, taking into account local morbidity trends protocols for HIV and STD patient treatment data on HIV and STD in the population LHD may conduct partner notification. Where the health plan conducts partner notification, the LHD can assist in the implementation of protocols Provide guidance on current recommendations on post-exposure prophylaxis for workplace	Provide HIV counselor training and certification Consult on quality assurance issues related to counseling and testing activities Coordinate drug assistance programs for persons living with HIV who meet specific requirements Coordinate professional education for primary care physicians and other health care provides on HIV laws, new treatments/prophylaxis

NO.	HEALTH PLAN SERVICES	COORDINATION AND COLLABORATION ROLES: HEALTH PLAN	LOCAL HEALTH DEPARTMENT (LHD)	MICHIGAN DEPARTMENT OF COMMUNITY HEALTH (MDCH)
	STANDARD: State laws for pre- and post-test HIV counseling, informed consent, confidentiality, and partner notification Disease Control Rules Sexually Transmitted Disease Guidelines, MMWR, Vol 42 no 14, 1993 Health Resources Admin guidelines for HIV/AIDS education and screening Public Health Service guidelines for counseling and antibody testing to prevent AIDS MMWR, Vol 36 509-15 MDCH Laboratory Users' Manual		exposures to blood or body fluids Provide referral information for HIV case management and other care services within the community Provide copies of applicable statutes, rules and LHD/MDCH reporting procedures; assist health plan in maintaining confidentiality, particularly on access to care for minors and HIV/AIDS care Provide education and prevention materials; conduct training and presentations When available, LHD can provide counseling, testing and treatment with pre-authorization of enrollee and will report encounter data to health plan, based on properly executed releases	Provide reference laboratory testing: HIV confirmatory testing, HIV 2 antibody testing, HIV viral load studies, neonatal and maternal PCR, reference testing for gonorrhea and syphilis and chlamydia culture; all according to state laboratory submission requirements
	c) TUBERCULOSIS Provide, authorize or contract for adequate testing, diagnosis and treatment according to state and federal guidelines Provide disease and prevention education to all high risk enrollees, including substance abusers Submit tuberculosis isolates to MDCH laboratory Report all suspect and confirmed cases to LHD Refer non-adherent patients promptly to LHD for directly observed therapy (DOT) and authorize DOT STANDARD: Proceeding of the 2nd National Conference of Laboratory Aspects of Tuberculosis, ASTPHLD, Washington, DC, 1996	Collaborate with MDCH to implement standardized testing and treatment protocols	Interview patient and contacts and identify additional cases in the community Provide directly observed therapy Collect, process and evaluate case reporting	Perform reference and epidemiological testing of the first isolate from each case and any isolate grown from a specimen more than 90 days after the original culture Provide standardized testing and treatment protocols
	d) IMMUNIZATION	Collaborate with LHD to implement childhood	LHD will report immunizations provided to enrollees	Provide confirmatory testing for

NO.	HEALTH PLAN SERVICES	COORDINATION AND COLLABORATION ROLES		
		HEALTH PLAN	LOCAL HEALTH DEPARTMENT (LHD)	MICHIGAN DEPARTMENT OF COMMUNITY HEALTH (MDCH)
	Provide vaccinations Conduct individual provider assessments and feedback Participate in immunization registry Comply with state and national storage and handling protocols for vaccines, assuring maintenance of proper equipment Report all suspect cases of vaccine-preventable disease to LHD Report immunization adverse reactions to the national Vaccine Adverse Event Reporting System (VAERS) Refer all specimens for confirmation of vaccine-preventable illnesses to MDCH laboratory Screen all pregnant women for HBsAg; administer appropriate prophylaxis to infants born to HBsAg. positive mothers STANDARD: Advisory Committee on Immunization Practices and AAP Pediatrics Recommendations	and adult immunization protocols according to national recommendations as adopted in Michigan Report vaccine-preventable disease to LHD Cooperate with state and local health departments in disease and outbreak investigations	to appropriate health plans Investigate reports of vaccine preventable illnesses Provide provider education and training Provide resource materials Provide practice and provider assessment software and services Distribute vaccine for Medicaid eligible enrollees Assure availability of immunization services	vaccine-preventable illnesses and outbreak investigations Provide vaccine for Medicaid-eligible enrollees Develop and provide provider education materials Develop and provide resource materials Provide practice and provider assessment software and services Assist in outbreak investigation and intervention activities
2.	CHRONIC DISEASE a) BREAST AND CERVICAL CANCER Detection, treatment and follow-up Standards for early detection and follow-up care: Breast and Cervical Cancer Medical Protocol, Michigan Cancer Consortium Standards for mammography facilities and cytology laboratories:	Collaborate with LHDs and MDCH to incorporate breast and cervical cancer screening, follow-up and reminder data into plan monitoring or tracking systems Collaborate with LHDs and MDCH to develop culturally-sensitive strategies and educational materials to encourage women to be screened at age-appropriate frequencies Collaborate with LHDs to increase community awareness about breast and cervical cancer control	Assist plan development of monitoring systems Assist plan in development of strategies and educational material Collaborate with plan to implement projects to increase community awareness of breast and cervical cancer control	Provide LHD with technical assistance in monitoring system development, and collaborate as needed with plans Provide LHD with information on culturally-sensitive strategies and educational material, and collaborate as needed with plans, including evaluation efforts Serve as clearinghouse for community awareness projects in the state

NO.	HEALTH PLAN SERVICES	COORDINATION AND COLLABORATION ROLES: HEALTH PLAN	LOCAL HEALTH DEPARTMENT (LHD)	MICHIGAN DEPARTMENT OF COMMUNITY HEALTH (MDCH)
	State Requirements			
	b) DIABETES Detection, treatment and control including patient education STANDARDS: "Diabetes Care," American Diabetes Association (ADA) January Supplement I Michigan Diabetes Outpatient Education-Program Standards, 1992	Collaborate with the regional Diabetes Outreach Network to assure that the prevention and care provided to persons with or at risk for diabetes are consistent with the national guidelines	Participate in and assist in establishing and maintaining linkage between the health plan and the regional Diabetes Outreach Network.	Certify diabetes outreach programs and support regional networks
	c) CARDIOVASCULAR DISEASES (high blood pressure, high blood cholesterol, and smoking and physical inactivity risk factors) Detection, treatment and control including tobacco use prevention and education STANDARD: Human Blood Pressure Determination by Sphygmomanometry, Circulation Vol 88, No.5, Part 1, November 1993, pp 2460 2470 The Fifth Report of the Joint National Committee on Detection and Evaluation and Treatment of High Blood Pressure (NIH Pub No.93 1088, March 1994) Personal Health Guide from HHS, Put Prevention Info Practice The Second Report of the Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (NIH Pub # 93 3090, September 1993) Physical Activity and Health A Report of the Surgeon General Executive Summary. HHS and CDC US Government Printing Office (S/N 017-023-00 196-5) 1996	Collaborate with LHD and MDCH to implement use of professional consensus reports and guidelines, e.g., CDC recommendations for physician counseling for exercise called Physician-based Assessment and Counseling for Exercise (PACE) Program Participate in local coalitions related to CVD, tobacco reduction and physical inactivity	Participate in and assist health plan to establish and maintain linkage with the local physical fitness council to increase opportunities for exercise Participate in and assist health plan to develop linkages with local cardiovascular disease and tobacco coalition efforts Assure availability of community-based smoking/tobacco cessation programs Provide the health plan with professional consensus reports and guidelines	In cooperation with the Governor's Council on Physical Fitness, provide health plans with information about the Centers for Disease Control and Prevention's PACE Program and guidelines for sports injury prevention
3.	FAMILY PLANNING Diagnostic evaluation, drugs, supplies, devices, services, and related counseling	Enrollees have full freedom of choice, both in-plan and out of-plan; LHD may also be a service provider	Local family planning clinics (Title X) Coordinate delivery of recipient care with health plans	Title X delegate agency support to local family planning clinics

NO.	HEALTH PLAN SERVICES	COORDINATION AND COLLABORATION ROLES: HEALTH PLAN	LOCAL HEALTH DEPARTMENT (LHD)	MICHIGAN DEPARTMENT OF COMMUNITY HEALTH (MDCH)
	STANDARD: Contraceptive Technology, 1994 American College of Obstetricians and Gynecologist Guidelines for Women's Health Care and Standards for Obstetric-Gynecologic Services 1996, and Technical Bulletins Centers for Control Morbidity and Mortality Weekly Report (MOIRE), Vol 42, no 14, Sept. 14, 1993 CDC Guidelines for HIV Counseling and Voluntary Testing for Pregnant Women	Develop joint policy on confidentiality with other family planning providers, in cooperation with LHD Develop procedure for enhancing sharing of medical information which may affect health and/or reproductive needs	Assist in the development of joint policy on confidentiality between health plans and other family planning providers	
4.	PRENATAL AND POSTPARTUM CARE Provide mandatory counseling and voluntary testing for HIV, STD, and hepatitis B to pregnant women STANDARD: American College of Obstetrician Gynecologist American Academy of Pediatrics Guidelines for Perinatal Care third edition Prevention of Perinatal Group B Streptococcal Disease A Public Health perspective, Morbidity and Mortality Weekly Report vol 45, no RR-7, May 31, 1996 US Public Health Service Recommendations for Human Immunodeficiency Virus Counseling and Voluntary Testing for Pregnant Women, Morbidity and Mortality Weekly Report, vol 44, no.RR-7, July 7, 1995 Michigan Compiled Laws (Public Act 368, 1978 as amended) Section 5123, 5131, 5133 Health Resources and Services Administration "Use of Zidovudine (ZDV) to Reduce Perinatal Transmission of HIV/AIDS," 1995 US Department Health and Human Services, Public Health Services, Substance Abuse and Mental Health Services Administration, Pregnant Substance Using Women, Treatment Improvement Protocol	Assess enrollees' understanding of how to access prenatal care in the managed care system, and refer enrollees to Medicaid managed care ombudsman programs as needed Develop protocols on minors' access to care in collaboration with LHD, to assure compliance with state law Refer eligible enrollees to WIC and other community-based services	Community education about the need for early and regular prenatal and postpartum care Assist women info care via outreach and advocacy Promote the development of community resources for support of childbearing families Conduct local smoking cessation/intervention programs Collaborate with health plans in development of protocols for minors' access to care	Support local agencies in educating and assisting women info care

NO.	HEALTH PLAN SERVICES	COORDINATION AND COLLABORATION ROLES		
		HEALTH PLAN	LOCAL HEALTH DEPARTMENT (LHD)	MICHIGAN DEPARTMENT OF COMMUNITY HEALTH (MDCH)
	(TIP) Institute of Medicine, Nutrition During Pregnancy and Lactation, Implementation Guide 1992			
5.	MATERNAL AND INFANT SUPPORT SERVICES Screen all pregnant and postpartum women and infants to determine risk for poor birth outcomes Provide or authorize MSS/ISS services STANDARD: Medical Services Bulletin and Infant Support Services Providers 95-01, 95-03, and 93-03	Collaborate with LHD to implement MSS and ISS protocols If the health plan contracts for MSS/ISS services, it must do so only with certified providers	Certified and skilled MSS/ISS providers are available through LHD and other community agencies	Certify and monitor MSS and ISS
6.	LABORATORY Diagnostic laboratory and x-ray services Provide for specimen or isolate collection and transportation to MDCH laboratory, for testing to support outbreak investigation and surveillance studies (including but not limited to all initial isolates of Mycobacterium tuberculosis, Salmonella, Shigella and E.coli O 157:H7 and any cultures isolate 90 days or more from the initial isolate; serum specimens from suspect cases of vaccine-preventable illness; isolates of highly resistant invasive microorganisms) Complete laboratory reporting requirements Cooperate with LHD and MDCH in outbreak investigation and disease surveillance studies STANDARD: Disease Control Rules MDCH Laboratory Users Guide Second National Conference on Serological Diagnosis of Lyme Disease, MMWR Vol 44 (no 31)	Arrange for specimen transport to MDCH laboratory. Assist LHD, local animal control officials and veterinarians in locating animals responsible for having bitten enrollees Coordinate appropriate rabies prophylaxis vaccination with LHD	Assist in specimen collection and transportation to MDCH Laboratory Assist interpretation of certain laboratory results to plan physicians and enrollees	Develop laboratory-based surveillance study protocols and perform appropriate reference and epidemiological testing Perform rabies testing on unvaccinated or wild animals Provide MDCH Laboratory Users Guide See laboratory roles related to health plan service #1, Communicable Diseases

NO.	HEALTH PLAN SERVICES	COORDINATION AND COLLABORATION ROLES: HEALTH PLAN	LOCAL HEALTH DEPARTMENT (LHD)	MICHIGAN DEPARTMENT OF COMMUNITY HEALTH (MDCH)
	Proceedings of the Second National Conference on Laboratory aspects of Tuberculosis ASTPHLD, 1996 Sexually Transmitted Disease Guidelines MMWR Vol 42 (RR 14) 1993 Public Health Service Guidelines for Counseling and Antibody Testing to Prevent HIV infection and AIDS MMWR Vol 36, 1987 Interpretation and Use of the Western Blot Assoy for Serodiagnosis of HIV type 1 Infections MMWR, Vol 38, 1989			
7.	LEAD SERVICES Provide lead poisoning prevention education Submit blood specimens for all children to MDCH laboratory for blood lead testing Refer all children who develop toxic lead levels to LHD for environmental testing at MDCH laboratory Refer to LHD for environmental and nursing investigations and follow-up and referrals for environmental remediation. STANDARD: Preventing Lead Poisoning in Young Children. Centers for Disease Control and Prevention 1991	Coordinate environmental and nursing investigations and community education programs with LHD Refer and authorize every child with an elevated blood lead level for an environmental and in-home nursing follow-up	Analyze data to identify exposure patterns Develop primary prevention services Coordinate prevention and environmental remediation programs Facilitate referrals and consultation to Children's Medical Specialty Clinics Provide referrals to support services, for example EarlyOn	Provide environmental assessment and nursing investigations and abatement programs Provide lead poisoning prevention education programs Provide blood lead and environmental testing
8.	WELL CHILD CARE (EPSDT) Provide or authorize screening services and needed follow-up care Accept and take action on referrals from community-based school health, hearing and vision screening programs Use every encounter as an opportunity to immunize children and adolescents	Refer eligible enrollees for community based support and follow-up services including but not limited to EarlyOn (under three years old) CSHCS, the Intermediate school district, (special education) vocational rehabilitation (16 years old and up) Collaborate with local SAFE KIDS Coalitions to disseminate injury prevention educational materials and safety equipment Collaborate with school-based and adolescent	Provide community health education to promote the need for regular, routine well child and well-adolescent preventive health screen Assure school based vision and hearing screening programs and referral of all children needing follow-up to the health plan Appropriate reporting to Lead Surveillance System at MDCH Assist health plan in referring enrollees to local or	Support community efforts that educate and promote enrollees accessing their health care provider Regular update of quality standards and recommendations for hearing and vision screening service Provide training for preschool and school aged hearing and vision screening

NO.	HEALTH PLAN SERVICES	COORDINATION AND COLLABORATION ROLES		
		HEALTH PLAN	LOCAL HEALTH DEPARTMENT (LHD)	MICHIGAN DEPARTMENT OF COMMUNITY HEALTH (MDCH)
	STANDARD: American Pediatrics Association Schedule for periodicity for well child services Medical Services Administration Bulletin American Medical Association Guidelines for Adolescent Preventive Services	health centers to assure the provision of primary care, psycho-social and health education services which are accessible and acceptable to youth.	state-level SAFE KIDS Coalition for information on obtaining low-cost safety equipment, e.g., child safety seats, bike helmets, smoke detectors School-based and adolescent health centers will continue to promote collaboration with health plans in the provision of primary care, psycho-social and health education services which are accessible and acceptable to youth.	Develop practice parameters for appropriate health care practitioner counseling based on the National SAFE KIDS Home Safety Check endorsed by former Surgeon General C. Everett Koop Encourage use of E-codes (ICD9-CM external cause of injury codes) and provide education to increase awareness of their importance in prevention planning, as recommended by the Centers for Disease Control and Prevention and the National Highway Traffic Safety Administration

APPENDIX B

Model Local Agreement with Behavioral Provider

Model Agreement Between HEALTH PLAN and Local Behavioral Health Contractor,
(Community Mental Health Service Program, CMHSP)

The agreements between the Qualified Health Plan and the local behavioral health contractor (CMHSP) must incorporate and address all of the items and areas listed and described below. These standard provisions are as follows:

- Legal Basis
- Term of Agreement
- Administration
- Areas of Shared Responsibility
  - Referral
  - Interagency Assessment and Supports/Services Planning
  - Emergency Services
  - Pharmacy and laboratory service coordination
  - Medical Coordination
  - Quality Improvement coordination
  - Data and reporting requirements
  - Grievance and complaint resolution
  - Dispute Resolution
- Indemnification
- Governing Laws

This agreement is made and entered into this___________day of______, 20___by and between __________________and_______________________.
(Health Plan) (CMHSP)

(1) Legal Basis

Whereas, P.A. 352 of the Public Acts of 1996 permits the Department of Community Health to increase the enrollment of Medicaid eligible persons in qualified health plans on a capitated basis; and

Whereas, in order to expand enrollment the Department of Community Health has established a competitive bid process that has resulted in contracts with health plans that are deemed to be qualified to provide specified health care services to Medicaid enrollees; and

Whereas, the majority of Medicaid covered mental health services will be provided through arrangements between the Department of Community Health and selected behavioral health providers; and

Whereas, Community Mental Health Service Programs, CMHSP, are designated as the Behavioral Health Provider under contract with the Department of Community Health and consistent with the Mental Health Code; and

Whereas, qualified health plans and CMHSPs should coordinate and collaborate efforts in order to promote and protect the health of Medicaid enrolled population;

Now, therefore the Qualified Health Plan and the CMHSP agree as follows:

(2) Term of Agreement

This agreement will be effective_____________20____for a period not to exceed_______________. The agreement will be subject to amendment due to changes in the Contracts between the Department of Community Health and the Qualified Health Plan or the contract with the Community Mental Health Services Programs.

Upon signed agreement of both parties, the provisions of this agreement will be extended for a time frame consistent with the contract period of the Qualified Health Plan and the Department of Community Health. Either party may cancel the agreement upon 30 day written notice.

(3) Administration and Point of Authority

The Qualified Health Plan shall designate in writing to the CMHSP the person who has authority to administer this agreement. The CMHSP shall designate in writing to the Qualified Health Plan the person who has authority to administer this agreement.

(4) Areas of Shared Responsibility

In order to provide the most efficient and coordinated services to Medicaid enrollees, the responsibilities of the Qualified Health Plan and CMHSP will include:

(A) Referral

Mutually Served Consumers

This refers to Qualified Health Plan members who also receive specialized CMHSP behavioral health services. Mutual consumer groups will be defined according to clinical criteria agreed upon between the individual CMHSP and Qualified Health Plan. For adults with severe and persistent mental illness and for children and adolescents with severe emotional disturbance the criteria should be based upon the combination of diagnosis, degree of disability, duration, and prior service utilization. Services to be provided by the Qualified Health Plan and by CMHSP may vary for different clinically defined groups.

Entry to CMHSP Specialized Behavioral Health Services

This is the process of obtaining CMHSP approval for a Qualified Health Plan member to receive specialized behavioral health services from CMHSP. Specialized behavioral health services means those provided by a psychiatric hospital or inpatient unit of a community hospital, partial hospitalization services or those unique services of CMHSP which support persons in community environments and/or provide alternatives to, or decrease the need for psychiatric inpatient services or state facility services. These might include such services as assertive community treatment, specialized residential services, day program services, Mental Health Clinic services, psychosocial rehabilitation services, home based services, etc.

Services To Be Provided (Benefit Packages and Limitations)

The intent of establishing written procedures between Qualified Health Plans and CMHSP Programs is to assure service coordination and continuity of care for persons receiving services from both organizations. Therefore it is essential that the parties define the service/coverage package which will be provided by each party to mutual consumers. This must also specify any limitations on amounts of services, including but not restricted to:

- emergency services
- inpatient psychiatric hospital and other hospital services
- outpatient mental health services
- physician, especially neurological assessments and treatment, diagnostics, and orders for therapies;
- pharmacy and laboratory services
- therapies (physical, occupational, speech)

- Mental Health Clinic Services
- personal care services, including Home Help and specialized Mental Health personal care
- substance abuse services
- transportation to medical services & to Mental Health services

(B) Interagency Assessment and Supports/Services Planning

This includes collaborative joint supports/services, and/or treatment planning activities of the consumer, the CMHSP Program and the Qualified Health Plan regarding mental health services, specialty developmental disability services and medical services provided by each party to the mutual consumer.

It includes identifying responsibilities to, and processes for: joint service planning meetings; sharing of assessments and background information; employing person-centered processes to develop supports/services plans; assigning supports/services coordination responsibilities; ongoing monitoring (inclusive of health status) and communication about services rendered or additional services needed.

The two parties must establish a process for clinical staffings in order that the clinical staff of the two agencies meet on a regular basis to review the plans and status of mutual consumers.

The interagency treatment/supports planning process further involves sharing of written documents and verbal reports, and discussions at joint supports/services planning meetings.

(C) Emergency Services.

In accordance with the definition of emergency services described in Section II-I-1 of CONTRACT for Comprehensive Health Care Program, emergency services also include those services provided to a person suffering from an acute problem in behavior or mood which requires immediate intervention. The need for the intervention may be identified by the enrollee, the enrollee's family or social unit, other agencies or referral sources, or law enforcement personnel.

It is the responsibility of the Qualified Health Plan to ensure that emergency services are available 24 hours a day and 7 days a week. As part of its responsibilities to provide emergency services and mental health outpatient services, the Qualified Health Plan must make available mental health crisis services; for its enrollees. This applies for all enrollees except for those who are receiving specialized behavioral health services. If the emergency is of a medical/physical nature, it is the responsibility of the Qualified Health plan.

The Qualified Health plan has the responsibility to inform all enrollees of emergency service procedures for accessing emergency services and to inform members of the designated emergency phone number through member services materials and programs. Prior approval by the Qualified Health Plan is not required.

It is the responsibility of the CMHSP to provide for emergency mental health services for all enrollees receiving specialized behavioral health services including:

- access by telephone 24 hours a day, seven days a week. Such number shall be made available to the qualified health plan to provide to all enrollees;
- provision for face-to-face services to persons in need of crisis evaluation, and admission screening for psychiatric inpatient admissions, intervention and disposition.

(D) Pharmacy and Laboratory Services

Prescriptions and Orders for Laboratory Services:

1. Unless agreed to by the CMHSP, the Qualified Health Plan cannot restrict prescriptions written by the behavioral health physicians as long as:

   (a) The drug prescribed is for the treatment of mental illness or substance abuse and any side effects of psychopharmacological agents.
   (b) The purchase is made from an approved Qualified Health Plan pharmacy.

2. The Qualified Health Plan cannot restrict orders for laboratory services to test for and monitor the medications prescribed by the behavioral health physician, except that the laboratory must be approved by the Qualified Health Plan.

3. The Qualified Health Plan and the CMHSP must develop approval mechanisms for other laboratory and imaging services (e.g. MRI, CAT scans, X-rays, etc).

Coordination:

1. The Qualified Health Plan and the CMHSP must develop procedures for notifying each other of prescriptions, and when deemed advisable, consultation between practitioners before prescribing medication, and sharing complete and up-to-date medication records.

2. The CMHSP in cooperation with the Qualified Health Plan is responsible to monitor and track pharmaceutical usage in order for the Qualified Health Plan to provide comprehensive data and information as required under contract with the Department of Community Health.

Pharmacies and Laboratories:

The qualified Health Plan must ensure that pharmacy and laboratory services are easily accessible to the recipients of the specialized behavioral health services. Strategies to accomplish this include the location of pharmacies and laboratories in proximity to specialty service locations and/or public transportation, home delivery services, or other methods of the provision of these services. The CMHSP shall assist the Qualified Health Plan in identifying existing locations used by consumers and/or alternative delivery strategies.

Drug Formulary:

1. The Qualified Health Plan drug formulary for developmental disabilities and for behavioral health must include all of the drugs currently covered for the Medicaid FFS population.

2. The Qualified Health Plan must have a process to evaluate requests to add products not included in its drug formulary.

(E) Medical Coordination

In order to coordinate the appropriate delivery of health care services to Medicaid enrollees clarity regarding the respective responsibility is necessary. Both parties will develop referral procedures and effective means of communicating the need for individual referrals.

It is the responsibility of Qualified Health Plans to provide or arrange for a limited number of outpatient visits (20 visits). The Qualified Health Plan may contract with CMHSP to provide this benefit. Payment for these services are the responsibility of the Qualified Health Plan.

It is the responsibility of the CMHSP to provide or arrange for all inpatient (including entry and exit from state facilities) services and specialty mental health services. Payment for these services will be the responsibility of the CMHSP and Department of Community Health.

Health and Medical Services: A number of mutually served consumers will be jointly under the care of at least two physicians, namely the Qualified Health Plan primary health care physician and the specialty behavioral health physician. The treatment planning process must clearly define the respective responsibilities for these two physicians. On an individual consumer basis other health related services will need to be clarified. Such health related services include nutrition/dietary, maintenance of health and hygiene, nursing services, teaching self-administration of medications, etc.

It is jointly the responsibility of the Qualified Health Plan and CMHSP to conduct utilization review for Medicaid enrollees. This is defined as the process of evaluating the necessity, appropriateness and efficiency of health care services. The information developed in this process is essential to the Quality Improvement Plans of each party.

(F) Quality Improvement

Both parties agree that a set of Quality Improvement activities to monitor the coordination of services is necessary. The Quality Improvement process will establish performance standards that will be used to monitor access, coordination, outcome, and satisfaction of services.

(G) Data and Reporting Requirements and Release of Information

Both parties will agree to coordinate the data sharing necessary for completing reporting requirements established through their respective contracts with the Department of Community Health. Such data sharing should involve performance indicators such as:

- mental health emergency services including pre-admission screening for psychiatric inpatient services
- inpatient utilization
- referrals to CMHSP specialized mental health services
- pharmacy and laboratory utilization
- coordination between the Qualified Health Plan and the CMHSP
- consumer/enrollee satisfaction with services and coordination.

Both parties shall agree to obtain any necessary signed releases of information from the enrollee so that treatment information can be shared without impediment between the two parties to this agreement. The Mental Health Code stipulates that the holder of the mental health record may disclose information "as necessary in order for the recipient to apply for or receive benefits".

(H) Grievance and Complaint

Qualified Health Plans are required to establish internal processes for resolution of complaints and grievances from enrollee members. Medicaid enrollees may file a complaint or grievance on any aspect of service provided to them by the health plan or the health plan's contracted providers.

CMHSPs are required to establish second opinion mechanisms and internal recipient rights processes for resolution of complaints from recipients and others.

Both parties are responsible for informing the other about their consumer grievance and complaint process.

Both parties are responsible to provide information to Medicaid enrollee members regarding the health plan's grievance and complaint process and that of the CMHSP.

(I) Dispute Resolution

The parties must specify the steps that the Qualified Health Plan or CMHSP must follow to contest a decision or action by the other party related to the terms of the agreement. The process should specify the responsibilities of the parties and time frame for each step.

The dispute resolution process should include:

For administrative decisions:

- Request to the other party for reconsideration of the disputed decision or action.
- Appeal to the DCH regarding a disputed decision of a QHP, or for a disputed decision of a CMHSP.

For clinical decisions:

- Request to the other party for reconsideration of the disputed decision or action.
- Appeal to a locally-established clinical review team comprised of Medical Directors, or their designees, from the CMHSP and the Qualified Health Plan.
- Appeal to a clinical review team consisting of medical professionals representing the Department of Community Health.

(5) Indemnification

Both parties will agree to provisions that protect against liability in the performance of activities related to this agreement.

(6) Governing Laws

Both parties agree that performance under this agreement will be conducted in compliance with all federal, state, and local laws, regulations, guidelines and directives.

SIGNATURE

Approved as to form by local Counsel.

APPENDIX C

MODEL LOCAL AGREEMENT WITH DEVELOPMENTAL DISABILITY PROVIDER

Model Agreement Between HEALTH PLAN and Local Developmental Disability Contractor,
(Community Mental Health Service Program, CMHSP)

The agreements between the Qualified Health Plan and the local developmental disability contractor (CMHSP) must incorporate and address all of the items and areas listed and described below. These standard provisions are as follows:

- Legal Basis
- Term of Agreement
- Administration
- Areas of Shared Responsibility
  - Referral
  - Interagency Assessment and Supports/Services Planning
  - Emergency Services
  - Pharmacy and laboratory service coordination
  - Medical Coordination
  - Quality Improvement coordination
  - Data and reporting requirements
  - Grievance and complaint resolution
  - Dispute Resolution
- Indemnification
- Governing Laws

This agreement is made and entered into this ___________ day of ___________, 20____ by and between _________________________ (Health Plan) and ___________________________ (CMHSP).

(1) Legal Basis

Whereas, P.A. 352 of the Public Acts of 1996 permits the Department of Community Health to increase the enrollment of Medicaid eligible persons in qualified health plans on a capitated basis; and

Whereas, in order to expand enrollment the Department of Community Health has established a competitive bid process that has resulted in contracts with health plans that are deemed to be qualified to provide specified health care services to Medicaid enrollees; and

Whereas, specialized services for Medicaid enrollees who have developmental disabilities will be provided through arrangements between the Department of Community Health and selected developmental disability providers; and

Whereas, Community Mental Health Service Programs, CMHSP, are designated as the Developmental Disability Provider under contract with the Department of Community Health and consistent with the Mental Health Code; and

Whereas, qualified health plans and CMHSPs should coordinate and collaborate efforts in order to promote and protect the health of Medicaid enrolled population;

Now, therefore the Qualified Health Plan and the CMHSP agree as follows:

(2) Term of Agreement

This agreement will be effective _________________ 20____ for a period not to exceed _____________. The agreement will be subject to amendment due to changes in the contracts between the Department of Community Health and the Qualified Health Plan or the contract with the Community Mental Health Services Programs.

Upon signed agreement of both parties, the provisions of this agreement will be extended for a time frame consistent with the contract period of the Qualified Health Plan and the Department of Community Health. Either party may cancel the agreement upon 30 day written notice.

(3) Administration and Point of Authority

The Qualified Health Plan shall designate in writing to the CMHSP the person who has authority to administer this agreement. The CMHSP shall designate in writing to the Qualified Health Plan the person who has authority to administer this agreement.

(4) Areas of Shared Responsibility

In order to provide the most efficient and coordinated services to Medicaid enrollees, the responsibilities of the Qualified Health Plan and CMHSP will include:

(A) Referral

Mutually Served Consumers

This refers to Qualified Health Plan members who also receive CMH services. Mutual consumer groups will be defined according to clinical criteria agreed upon between the individual CMH and Qualified Health Plan. Services to be provided by the Qualified Health Plan and by CMH may vary for different clinically defined groups. Eligibility criteria for specialty developmental disability (DD) services are outlined in Attachment 1. It should be noted that persons who receive specialty developmental disability services also have a high likelihood of requiring behavioral health services.

Entry to CMHSP Specialized Services for Persons with DD

This is the process of obtaining CMHSP approval for a Qualified Health Plan member to receive specialized DD services from CMHSP. Specialized DD services means those unique services of CMHSP which support persons in community environments and/or provide alternatives to, or decrease the need for, Intermediate Care Facilities for persons with Mental Retardation (ICFs/MR) which includes State DD Centers and Alternative Intermediate Services for Persons with Mental Retardation (AIS/MR) homes. These might include such services as specialized residential services, day program services, outpatient Mental Health Clinic services, supportive services (e.g., family support, supported independent living), etc.

Services To Be Provided (Benefit Packages and Limitations)

The intent of establishing written procedures between Qualified Health Plans and CMHSP Programs is to assure service coordination and continuity of care for persons receiving services from both organizations. Therefore it is essential that the parties define the service/coverage package which will be provided by each party to mutual consumers. This must also specify any limitations on amounts of services, including but not restricted to:

- emergency services
- inpatient hospital, and outpatient services by type of outpatient service
- intermittent/short term LTC nursing facility stays
- physician, especially neurological assessments and treatment, diagnostics, and orders for therapies;
- pharmacy, particularly drugs used in seizure and/or behavioral management and the OTC and non-prescription items commonly ordered for consumers with DD

- laboratory services
- dental services
- therapies (physical, occupational, speech)
- Mental Health Clinic Services
- home health services, including hourly nursing
- medical equipment and supplies, and assistive technology
- specialized DD services, including home and community-based care, crisis stabilization, and long-term supports
- personal care services, including Home Help and specialized Mental Health personal care
- transportation to medical services & to Mental Health services

(B) Interagency Assessment and Supports/Services Planning

This includes collaborative joint supports/services, and/or treatment planning activities of the consumer, the CMHSP Program and the Qualified Health Plan regarding specialty developmental disability services, mental health services, and medical services provided by each party to the mutual consumer.

It includes identifying responsibilities to, and processes for: joint service planning meetings; sharing of assessments and background information; employing person-centered processes to develop supports/services plans; assigning supports/services coordination responsibilities; ongoing monitoring (inclusive of health status) and communication about services rendered or additional services needed.

For persons with developmental disability, a critical responsibility that needs to be identified relates to the physician responsibilities. This will need to be handled on an individual basis, but the process must be clearly laid out for defining the respective responsibilities of the CMHSP physician and the CHPP primary physician

The two parties must establish a process for clinical staffings in order that the clinical staff of the two agencies meet on a regular basis to review the plans and status of mutual consumers.

The interagency treatment/supports planning process further involves sharing of written documents and verbal reports, and discussions at joint supports/services planning meetings.

(C) Emergency Services.

In accordance with the definition of emergency services described in Section II-I-1 of the Request for Proposal for Comprehensive Health Care Program, emergency services also include those services provided to a person suffering from an acute problem in behavior or mood that requires immediate intervention. The need for the intervention may be identified by the enrollee, the enrollee's family or social unit, other agencies or referral sources, or law enforcement personnel.

It is the responsibility of the Qualified Health Plan to ensure that emergency services are available 24 hours a day and 7 days a week. As part of its responsibilities to provide emergency services and mental health outpatient services, the Qualified Health Plan must make available mental health crisis services for its enrollees. This applies for all enrollees except for those who are receiving specialized behavioral health services. If the emergency is of a medical/physical nature, it is the responsibility of the Qualified Health plan. If the emergency results from crises in the supports system of the consumer it is the responsibility of the specialty developmental disability provider.

The Qualified Health plan has the responsibility to inform all enrollees of emergency service procedures for accessing emergency services and to inform members of the designated emergency

phone number through member services materials and programs. Prior approval by the Qualified Health Plan is not required.

It is the responsibility of the CMHSP to provide for emergency mental health services for all enrollees receiving specialized behavioral health services including:

- access by telephone 24 hours a day, seven days a week. Such number shall be made available to the qualified health plan to provide to all enrollees;
- provision for face-to-face services to persons in need of crisis evaluation, and admission screening for psychiatric inpatient admissions, intervention and disposition.

(D) Pharmacy and Laboratory Services

Prescriptions and Orders for Laboratory Services:

1. Unless agreed to by the CMHSP, the Qualified Health Plan cannot restrict prescriptions written by the developmental disability physicians as long as:

   a. The drug prescribed is for the treatment of the developmental disability or for any complication due to the developmental disability.
   b. The purchase is made from an approved Qualified Health Plan pharmacy.

2. The Qualified Health Plan cannot restrict orders for laboratory services to test for developmental disabilities or the complications due to the disability, except that the laboratory must be approved by the Qualified Health Plan.

3. The Qualified Health Plan cannot restrict orders for laboratory services to test for and monitor the medications prescribed by the developmental disability services physician, except that the laboratory must be approved by the Qualified Health Plan.

4. The Qualified Health Plan and the CMHSP must develop approval mechanisms for other laboratory and imaging services (e.g. MRI, CAT scans, X-rays, etc).

Coordination:

1. The Qualified Health Plan and the CMHSP must develop procedures for notifying each other of prescriptions, and when deemed advisable, consultation between practitioners before prescribing medication, and sharing complete and up-to-date medication records.
2. The CMHSP in cooperation with the Qualified Health Plan is responsible to monitor and track pharmaceutical usage in order for the Qualified Health Plan to provide comprehensive data and information as required under contract with the Department of Community Health.

Pharmacies and Laboratories:

The qualified Health Plan must ensure that pharmacy and laboratory services are easily accessible to the recipients of developmental disability services. Strategies to accomplish this include the location of pharmacies and laboratories in proximity to specialty service locations and/or public transportation, home delivery services, or other methods of the provision of these services. The CMHSP shall assist he Qualified Health Plan in identifying existing locations used by consumers and/or alternative delivery strategies.

Drug Formulary:

1. The Qualified Health Plan drug formulary for developmental disabilities and for behavioral health must include all of the drugs currently covered for the Medicaid FFS population.

2. The Qualified Health Plan must have a process to evaluate requests to add products not included in its drug formulary.

(E) Medical Coordination

In order to coordinate the appropriate delivery of health care services to Medicaid enrollees clarity regarding the respective responsibility is necessary. Both parties will develop referral procedures and effective means of communicating the need for individual referrals.

In addition, both the Qualified Health Plan and CMHSP acknowledge respective individual responsibilities as listed below:

.. Habilitation and rehabilitation services. Habilitation services means those services designed to assist Medicaid enrollees in the development of skills and capacities they have never possessed, (i.e., predominantly in the functioning areas of self-care and/or activities of daily living), and to maintain capacities attained for the first time. Habilitation services are the responsibility of the CMHSP. Rehabilitation services are designed to assist Medicaid enrollees in restoring those self care skills they once possessed and is the responsibility of the Qualified Health Plan.

.. Case Management: Case management services means those services which will assist Medicaid enrollees in gaining access to needed medical, social, educational and other services. It is the expectation that Qualified Health Plans will demonstrate a commitment to assisting enrollees in managing their complex health care needs (Section II-T of the Request for Proposal for Comprehensive Health Care Program).

Within the developmental disabilities specialty services system case management includes: assessment; person-centered service plan development; linking/coordination of services; reassessment/follow-up; advocacy and monitoring of services. Some CMHSP consumers of DD services receive these case management services under a coverage entitled "supports coordination". As part of the referral procedures described above, the Qualified Health Plan and CMHSP shall both indicate the manner in which case management services will be coordinated.

.. Health and Medical Services: A number of mutually served consumers will be jointly under the care of at least two physicians, namely the Qualified Health Plan primary health care physician and the specialty developmental disabilities physician. The treatment planning process must clearly define the respective responsibilities for these two physicians. On an individual consumer basis other health related services will need to be clarified. Such health related services include nutrition/dietary, maintenance of health and hygiene, nursing services, teaching self-administration of medications, etc.

It is jointly the responsibility of the Qualified Health Plan and CMHSP to conduct utilization review for Medicaid enrollees. This is defined as the process of evaluating the necessity, appropriateness and efficiency of health care services. The information developed in this process is essential to the Quality Improvement Plans of each party.

(F) Quality Improvement

Both parties agree that a set of Quality Improvement activities to monitor the coordination of services is necessary. The Quality Improvement process will establish performance standards that will be used to monitor access, coordination, outcome, and satisfaction of services.

(G) Data and Reporting Requirements and Release of Information

Both parties will agree to coordinate the data sharing necessary for completing reporting requirements established through their respective contracts with the Department of Community Health. Such data sharing should involve performance indicators such as:

- mental health emergency including pre-admission screening for DD Centers or AIS/MR services
- referrals to CMHSP specialized developmental disabilities services
- Pharmacy and Laboratory utilization
- coordination between the QHP and the CMHSP
- Consumer/enrollee satisfaction with services and coordination.

Both parties shall agree to obtain any necessary signed releases of information from the enrollee so that treatment information can be shared without impediment between the two parties to this agreement. The Mental Health Code stipulates that the holder of the mental health record may disclose information "as necessary in order for the recipient to apply for or receive benefits".

(H) Grievance and Complaint

Qualified Health Plans are required to establish internal processes for resolution of complaints and grievances from enrollee members. Medicaid enrollees may file a complaint or grievance on any aspect of service provided to them by the health plan or the health plan's contracted providers.

CMHSPs are required to establish second opinion mechanisms and internal recipient rights processes for resolution of complaints from recipients and others.

Both parties are responsible for informing the other about their grievance and complaint processes.

Both parties are responsible to provide information to Medicaid enrollee members regarding the health plan's grievance and complaint processes and that of the CMHSP.

(I) Dispute Resolution

The parties must specify the steps that the Qualified Health Plan or CMHSP must follow to contest a decision or action by the other party related to the terms of the agreement. The process should specify the responsibilities of the parties and time frame for each step.

The dispute resolution process should include:

For administrative decisions:

- Request to the other party for reconsideration of the disputed decision or action.
- Appeal to the DCH regarding a disputed decision of a QHP, or for a disputed decision of a CMHSP.

For clinical decisions:

- Request to the other party for reconsideration of the disputed decision or action.
- Appeal to a locally-established clinical review team comprised of Medical Directors, or their designees, from the CMHSP and the Qualified Health Plan.
- Appeal to a clinical review team consisting of medical professionals representing the Department of Community Health.

(5) Indemnification

Both parties will agree to provisions that protect against liability in the performance of activities related to this agreement.

(6) Governing Laws

Both parties agree that performance under this agreement will be conducted in compliance with all federal, state, and local laws, regulations, guidelines and directives.

SIGNATURE

Approved as to form by local Counsel.

ATTACHMENT 1

ELIGIBILITY CRITERIA
DEVELOPMENTAL DISABILITIES SERVICE CARVE OUT

Health plan members may be referred for specialized services for persons with developmental disabilities provided through Michigan Community Mental Health Services Programs (CMHSP) when the member meets one or more of the following criteria:

1. Meets the Michigan Mental Health Code definition of developmental disability;
2. Has a confirmed diagnosis of severe or profound mental retardation, or mild or moderate mental retardation in combination with cerebral palsy, physical disability, sensory impairment, or challenging behaviors;
3. Has a documented IQ of 70 or below;
4. Has a designation of SMI, SXI, AI or TMI established by the school system;
5. Has a documented developmental delay based on administration of a standardized developmental test, such as the Denver Developmental Screening or the Gesell Developmental Test.

Additionally, the individual must have an apparent need for, or have requested, one or more of these specialized services provided through the CMHSP system:

1. Inpatient services in a State Center for Persons with Developmental Disabilities.
2. Specialized residential services.
3. Day program services.
4. Outpatient Mental Health Clinic Services when the service is habilitative and part of a plan of comprehensive supports/services.
5. Emergency DD services as needed to augment emergency services provided by the health plan.
6. Supportive services.
7. Prevention programs.
8. Testing and assessments.
9. Other services, by mutual agreement of the Qualified Health plan and the CMHSP.

Persons who are referred to the CMHSP will be screened to determine the level of need. Services will be provided according to the service priorities specified in the Michigan Mental Health Code. Some services may be limited or not available, due to funding limitations or capacity restrictions.

APPENDIX D

FORMAT FOR PROFILES OF PRIMARY CARE PROVIDERS, SPECIALISTS, & ANCILLARY PROVIDERS

HEALTH PLAN'S PRIMARY CARE PROVIDER PROFILE

Health Plan
Name ______________________________________ County/Region _________________________

List alphabetically by category of Primary Care: Family Practice, General Practice, Internal Medicine, OB/GYN, Pediatrician, authorized Nurse Practitioner and Physician Assistant
This form may be duplicated by the bidder as necessary and the Profile must be submitted in this format on disk using Excel 5.0.

Category	Physician	Physician	Physician
Physician Name			
State License Number			
Board Certified or Eligible (Y/N)			
Practice Type (e.g. GYN, OB etc.)			
Office Location (Use separate column for each location/address)			
Office days			
Office hours			
Accept established Medicaid Patients only (Y/N)			
Accept New Medicaid Patients (Y/N)			
Total Medicaid Capacity			
Total Patient Capacity (Medicaid Medicare and Commercial)			
Physician provides prenatal and OB services (Y/N)			
Hospital admitting Priviliges (list hospitals)			
Other licensed health personnel in office (Y/N) if Y, list by type of personnel (e.g., PA, FNP, etc.)			
Affiliation status with Health Plan: (Employee, Contractual (signed contract--Plan and physician), Contractual (signed letter of intent)			

HEALTH PLAN'S HOSPITAL PROFILE

Health Plan
Name ______________________________________ County/Region _________________________

This form may be duplicated by the bidder as necessary and the Profile must be submitted in this format on disk using Excel 5.0.

Name of Hospital	Affiliation Status with Health Plan: Owned, Contractual with signed and dated Contract, Contractual with signed and dated letter of intent	Attachment (and any addition or deletion) of most recent American Hospital Association Guide describing Services provided by Hospital Attachment provided (Y/N)

HEALTH PLAN'S ANCILLARY HEALTH PROVIDER PROFILE

Health Plan Name ____

County/Region ____

Include the following information regarding ancillary health provider for at least the following providers:

Pharmacy	Laboratory	Physical Therapy	Occupational Therapy
Speech Therapy	Home Health	Durable Medical Equipment	Maternal/Infant Support Services
Hospice	Vision	Audiology	Ambulance Service
Radiology	Substance Abuse	Family Planning	FQHC/RHC
Mental Health	Orthotics	Prosthetics	Restorative/Rehab Facility
Local Health Dept.			

This form may be duplicated by the bidder as necessary and the Profile must be submitted in this format on disk using Excel 5.0. (Plans may attach a list of multiple providers (i.e, pharmacies)

Name of Ancillary Provider	Licensue Number (if applicable)	Office Location	Office Hours	Office Days (SMTWTFS)	Type of Service

HEALTH PLAN'S SPECIALTY PHYSICIAN PROFILE

Health Plan Name________________________________ County/Region _______________________________

Specialists may include:

	Allergists	Anesthesiologists	Cardiologists
Dermatologists	Endocrinologists	Emergency Medicine	Gastroenterologists
Hematologists	Neonatologists	Neurologists	Neurosurgeons
Oncologists	Ophthalmologists	Orthopedists	Otolaryngologists
Pathologists	Physiatrists	Plastic Surgeons	Psychiatrists
Podiatrists	Pulmonary Specialists	Radiologists	Rheumatologists
Surgeons-General	Surgeons-Oral	Surgeons-Specialists	Sports Medicine
Therapeutic Radiologists	Urologists	Infection Disease Specialist	

Group physicians in like specialities. This form may be duplicated by the bidder as necessary and the Profile must be submitted in this format on disk using Excel 5.0.

Category	Physician	Physician	Physician
Physician Name & Specialty			
State License Number			
Board Certified or Eligible (Y/N)			
Office Address (Use separate column for each location/address)			
Office Hours			
Office Days			
Hospital Admitting Privileges (list hospitals)			
Accepting established Medicaid patients only (Y/N)			
Accepting new Medicaid Patients (Y/N)			
Total Medicaid Capacity for Health Plan			
Total Capacity fol all patients (Medicaid, Medicare and Commercial)			

- ---

Affiliation Status with Health Plan:
Employee Contractual (signed and
dated contract), Contractual (signed and
dated letter of intent)

- ---

APPENDIX E

KEY CONTRACTOR PERSONNEL AUTHORIZATION FOR RELEASE OF INFORMATION

AUTHORIZATION FOR RELEASE OF INFORMATION
Michigan Department of Community Health

TO WHOM IT MAY CONCERN:

I authorize any representative or agent of the Michigan Department of Community Health bearing either the original or a copy of this authorization to obtain information from your files or other sources pertaining to my personal background including but not limited to:

- Employment History
- Criminal History, including but not limited to a check of the Computerized Criminal History (CCH) file
- Financial / Credit History
- Academic Records
- Professional Licensure, including a check for any disciplinary actions

I authorize you to release such information upon request of the bearer. This Authorization is executed with the full knowledge and understanding that the information is for official use by the Michigan Department of Community Health.

I release you, the institution, agency or establishment which you represent, including its officers, employees and related personnel, both individually and collectively, from any and all liability for damages of whatever kind, which may at any time result to me, my heirs, family or associates because of compliance with this Authorization for Release of Information, or any attempt to comply with it. Should there be any question as to the validity of the Authorization, you may contact me as indicated below:

Full Name (Typed or Printed)   Social Security Number *

- ---
Current Address (Number and Street, Apt. No., Etc.)   Date of Birth

- ---
City   State   ZIP Code   Telephone Number

Area Code (   ) Number
- ---
Driver License Number   State Issuing

- ---
Medical or Health Professional License Number   State Issuing

- ---
Authorizing Signature   Today's Date

- ---
Witness Signature   Witness Name (Typed or Printed)

- ---
* This information is confidential and protected by the Federal Privacy Act.

Subscribed and sworn to before me

this ________ day of _______________, 1997.

____

Notary Public __________________ County
State of Michigan
My Commission Expires: ________________

Authority: PA 352 of 1996
Completion: Is Voluntary
Consequence: Failure to submit form may delay completion of proposal review.

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, marital status, political beliefs or disability.

MSA-50 (5-97)

APPENDIX F

HEALTH PLAN REPORTING FORMAT AND SCHEDULE

[LOGO OF MDCH]

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

INSTRUCTIONS FOR COMPILING AND SUBMITTING

ANNUAL REPORT FOR LICENSED QUALIFIED HEALTH PLANS

Please submit the Annual Report in a 3-ring binder with tabs for each component report. Please prepare each component report in the format specified in the instructions and for the different product lines, as indicated. Please submit one complete copy each to the assigned licensing officer and contract manager.

TAB NO.	COMPONENT REPORT	PRODUCT LINE
	ADMINISTRATIVE	
1	Summary Annual Report for Subscribers	T
2	Health Plan Profile	T
	FINANCIAL	
3	Financial	*
	QUALITY	
4	Complaints & Grievances	M, T
5	Litigation	M, T
	UTILIZATION	
6	Enrollment	E
7	HEDIS	E
8	Abortion	M
9	Vaccine	M
	PROVIDER	
10	Physician Incentive Program (PIP) Reporting	M
	DOCUMENTS	
11	Provider Directory	E
12	Certificate of Coverage	E
13	Member Handbook	E

Product Line Key:

M = Medicaid
T = Total for all product lines
E = Each product line separately
* = NAIC format addresses product line information

[LOGO OF MDCH]

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

INSTRUCTIONS FOR COMPILING AND SUBMITTING

ANNUAL REPORT FOR LICENSED QUALIFIED HEALTH PLANS

1. Summary Annual Report for Subscribers. The summary shall contain a statement indicating that relevant documents are on file with the Department or the Insurance Bureau, as applicable, and with the plan, and are available for public inspection. The summary annual report to subscribers shall include: (a) a summary of current activities of the plan, (b) the current members of the governing body with identification of the subscriber representatives, and (c) the procedures for enrollee contact with the governing body members.

2. Health Plan Profile. Form MSA-126 (9-99) is attached.

3. Financial. A copy of: (a) the 1999 NAIC "Annual Statement" as submitted to the Insurance Bureau, reduced to 8 1/2" by 11," (b) the Michigan Insurance Bureau INS-317 "Revenue and Expense" Report for HMOs (10/98),(c) Management Discussion and Analysis, (d) Statement of Actuarial Opinion, (e) Compensation Schedule B (INS 86), and (f) certified audited financial statements for calendar year 1999.

4. Complaints and Grievances. Form MSA-131 (9-99) is attached.

5. Litigation. Form MSA-129 (9-99) is attached. This information should be submitted in a separate, sealed envelope marked "Confidential."

6. Enrollment. Form MSA-130 (9-99) is attached. Please provide a breakdown by each product line for each county in the plan's approved service area as of the end of the calendar year being reported.

7. HEDIS. This report is due on June 30. Please submit two (2) hard copies and two (2) electronic copies of the Medicaid and commercial HEDIS reports. Electronic submission must be on the data submission tool (DST) as distributed by NCQA. Please indicate if any HEDIS reports being submitted were audited. If audited, please provide the name of the firm conducting the audit and whether the auditing firm is NCQA-certified.

8. Abortion. Form MSA-128 (9-99) is attached.

9. Vaccine. Form MSA-127 (9-99) is attached.

10. Physician Incentive Program (PIP) Reporting. Use HCFA annual update format.

For each of the following, please provide a copy of the most current document for each product line:

11. Provider Directory.

12. Certificate of Coverage.

13. Member Handbook.

HEALTH PLAN PROFILE
MICHIGAN DEPARTMENT OF COMMUNITY HEALTH   Report Date   Report Year

Please Type or Print Clearly

???RPORATED Name of Health Plan   HMO License Number

OPERATING Name of Health Plan   License Expiration Date

Describe the Ownership of Health Plan: (attach an organization chart)

Organization Status is:
[ ] PROFIT   [ ] NONPROFIT

Name of EXTERNAL Organization that has ACCREDITED Health Plan

Date Accreditation RECEIVED	Date Accreditation EXPIRES	TYPE of Accreditation Received

If NOT Accredited by an external organization, is accreditation being applied for?
[ ] NO   [ ] YES

If YES, Name of Organization from which the Health Plan has applied for accreditation

Date Accreditation Applied for   Expected Site Visit Date

KEY ADMINISTRATIVE STAFF: (Enter names as applicable)
. Also attach a list of Governing Body Members, indicate which members are elected enrollee members, and the date each member's term expires.

President	Medical Director
C.E.O.	Authorized Representative
C.O.O.	Quality Management Director
C.F.O.	Complaint / Grievance Director
C.I.O. / M.I.S. Director	Other (specify):

Number of Enrolled Members as of December 19____		Financial Information for Calendar Year ________	
Commercial.............	_______________	Total Revenues ...	_____________
Medicaid...............	_______________	Total Expenses....	_____________
Medicare Risk..........	_______________	Net Income (Loss).	_____________
Medicare Supplemental..	_______________	Working Capital...	_____________
Other..................	_______________	Other.............	_____________
TOTAL:	_______________	NET WORTH:	_______________

Name of Person Completing This Report (Typed or Printed)   Title

Signature   Telephone Number
(   )

Email Address

AUTHORITY: PA 368 of 1978, as amended or CHP Contract.
COMPLETION: Is Required. Failure to file this report may result in regulatory actions as permitted under PA 368 or sanctions as permitted under the CHP Contract.

The Department of Community Health is an equal opportunity employer, services, and programs provider.

MSA-126 (9-99)

HEALTH PLAN COMPLAINT/GRIEVANCE SUMMARY REPORT FOR 2000
MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

The purposes of this report, a Level 1 complaint is an issue a member presents to the health plan, either in written or oral form, requesting specific corrective action that can not be resolved at the time of initial contact. This Level 1 complaint is subject to formal review and investigation by the health plan, according to the health plan's written complaint/grievance procedure.

If a health plan has fewer levels of review in its complaint/grievance procedure than designated in this complaint/grievance summary, the health plan should note this by entering "NA" for the levels that do not exist. If a health plan has additional levels of review, the health plan should include the requested information on additional pages.

For each level of the health plan's complaint/grievance process, attach a short summary description of: (1) the individuals (by position title) who are involved in rendering a determination, and (2) the process and procedures of the health plan.

Enter Name of Health Plan   Report Date

2000 COMPLAINT / GRIEVANCE SUMMARY:

LEVEL 1:

Total Number of Level 1 complaints resolved in 2000..... ________________

Health plan's position was upheld...................... ________________

Health plan's position was overturned.................. ________________

A compromise resolution was reached.................... ________________

LEVEL 2:

Total Number of Level 2 complaints resolved in 2000..... ________________

Health plan's position was upheld...................... ________________

Health plan's position was overturned.................. ________________

A compromise resolution was reached.................... ________________

LEVEL 3:

Total Number of Level 3 complaints resolved in 2000..... ________________

Health plan's position was upheld...................... ________________

Health plan's position was overturned.................. ________________

A compromise resolution was reached.................... ________________

LAST LEVEL AVAILABLE TO A MEMBER WITHIN THE HEALTH PLAN:

Total Number of complaints in 2000 resolved at the health plan's last level.............................. ________________

Health plan's position was upheld...................... ________________

Health plan's position was overturned.................. ________________

A compromise resolution was reached.................... ________________

HMO TASK FORCE:

Number of complaints heard before the HMO Task Force and resolved in 2000.................................... ________________

Health plan's position was upheld .... ________________

Health plan's position was overturned.................. ________________

Settlement was reached before Task Force hearing........ ________________

MSA-131 (07-00)

OTHER COMPLAINT AND GRIEVANCE INFORMATION:

Please provide the number of Level 1 complaints resolved by the health plan in 2000 for each of the following categories,

Access: Administrative: Clinical:

Explain the actions being taken by the health plan to address these complaints.

____

____

____

____

In 2000, did the health plan resolve fewer or more complaints at each level than in 1999?

[ ] FEWER [ ] MORE

Explain the health plan's rationale for the changes in the number of complaints: (Use additional Sheets as Needed)

____

____

____

____

How many complaints took longer than 90 calendar days to resolve as allowed under MCL 333.21035(1)(c)............. ____________________

Information regarding the expedited grievances filed with the health plan during 2000 including:

1. Total number of expedited grievances filed with the health plan................................ ____________________
2. Total number of initial expedited grievance determinations made by the health plan ____________________

   i. Number of determinations made approving the member's request.......................... ____________________
   ii. Number of determinations made denying the member's request .... ____________________
   iii. Number of determinations denying the member's request resulting in a request for further review by the health plan...... ____________________
   iv. Number of determinations denying the member's request resulting in the member appealing to the Department................ ____________________

Name of Person Completing This Report (Typed or Printed)	Signature
Title	Area Code / Telephone Number ( )

AUTHORITY: PA 368 of 1978, as amended or CHP Contract.
COMPLETION: Is Required. Failure to file this report may result in regulatory actions as permitted under PA 368 or sanctions as permitted under the CHP Contract.

The Department of Community Health is an equal opportunity employer, services, and programs provider.

Page Of

Report Date

HEALTH PLAN MALPRACTICE LITIGATION REPORT

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

Health Plan Name

Report Year

INSTRUCTIONS:

- Please list all malpractice litigation for more than $50,000 that names any of the following as a party:
  - (1) the health plan,
  - (2) a provider contracted with the health plan, or
  - (3) an employee of the health plan.
- Attach additional pages as necessary.
- The state reserves the right to request additional information, as necessary.

MALPRACTICE LITIGATION:

DATE FILED	AMOUNT CLAIMED	STATUS (PENDING, SETTLEMENT, ETC.)	BRIEF DESCRIPTION OF CLAIM AND RESOLUTION (IF APPLICABLE)
LITIGATION PENDING FROM PREVIOUS CALENDAR YEAR			
LITIGATION FILED DURING REPORTING YEAR:			

Name of Person Completing Report
(Typed or Printed)

Title

Telephone Number
(   )

AUTHORITY: PA 368 of 1978, as amended or CHP Contract.

COMPLETION: Is Required. Failure to file this report may result in regulatory actions as permitted under PA 368 or sanctions as permitted under the CHP Contract.

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MSA-129 (9-99)

ANNUAL REPORT OF ENROLLMENT BY LINE OF BUSINESS AND COUNTY
MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

Page: Of:

INSTRUCTIONS: Copy and attach this form if needed to list additional counties.

Name of Health Plan | Report Date | Report Year

ENROLLMENT INFORMATION:

	COMMERCIAL ENROLLMENT by LINE OF BUSINESS or CONTRACT TYPE						GOVERNMENT RELATED ENROLLMENT				
COUNTY NAME	Commercial	Commercial POS	MIChild	Non-Group	OTHER Explain #1	Commercial Sub-Total	Medicaid	Medicare Risk	Medicare Supplemental	OTHER Explain	Government Sub-Total #2
						-					-
						-					-
						-					-
						-					-
						-					-
						-					-
						-					-
						-					-
						-					-
						-					-
						-					-
TOTALS:	-	-	-	-	-	-	-	-	-	-	-

COUNTY NAME	ENROLLMENT GRAND TOTAL
	-
	-
	-
	-
	-
	-
	-
	-
	-
	-
	-
TOTALS:	-

#1 - Explain OTHER (Line of COMMERCIAL Business):

#2 - Explain OTHER (Line of GOVERNMENT Business):

AUTHORITY: PA 368, of the Public Acts of 1978, as amended or CHP Contract.
COMPLETION: Is Required. Failure to file this report may result in regulatory actions as permitted under PA 368 or sanctions as permitted under the CHP Contract.

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- --
MSA-130 (Excel) (9-99)

HEALTH PLAN ABORTION REPORT

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

Page ____ Of ____

Report Date ____

Health Plan Name ____ Report Year ____

INSTRUCTIONS:
. Attach additional sheets as necessary.

The Health Plan covered abortions during this period for the following reasons:
(check only ONE)

BENEFICIARY ID NUMBER	RAPE	INCEST	TO SAVE LIFE OF MOTHER
	[ ]	[ ]	[ ]
	[ ]	[ ]	[ ]
	[ ]	[ ]	[ ]
	[ ]	[ ]	[ ]
	[ ]	[ ]	[ ]
	[ ]	[ ]	[ ]
	[ ]	[ ]	[ ]
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	[ ]	[ ]	[ ]
	[ ]	[ ]	[ ]
	[ ]	[ ]	[ ]
TOTALS: -->			

Name of Person Completing Report (Typed or Printed) ____ Title ____

Telephone Number ( )

AUTHORITY: CHP Contract
COMPLETION: Is Required. Failure to file this report may result in sanctions as permitted under the CHP Contract.

The Department of Community Health is an equal opportunity employer, services, and programs provider.

MSA-0128 (9-99) (W)

HEALTH PLAN VACCINE DOSE REPORT

Report Date ________________

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

____

Health Plan Name

Report Year

BACKGROUND:
One of the important health services that health plans provide is immunizations. Most vaccines for immunizations that are covered for Medicaid beneficiaries are available free from the Local Health Department. The Vaccines for Children (VFC) Program provides free vaccines for all Medicaid eligibles age 18 and under and the Michigan Vaccine Replacement Program (VPR) provides hepatitis B, MMR, OPV, TD, and IPV, free for all beneficiaries age 19 and older. Most physicians who immunize Medicaid patients are already taking advantage of this program.

The federal government requires accountability for vaccines distributed through the VFC. Until contracting health plans have fully operational encounter data reporting systems, it is necessary that all plans continue to report vaccine use.

The report below is to be used for this requirement, or you may develop your own report mechanism that provides the requested information.

VACCINE DOSE REPORT:

VACCINE NAME	HCPCS CODE	NUMBER OF DOSES AGE 18 AND UNDER	NUMBER OF DOSES AGE 19 AND OLDER
DTaP	90700		N/A
DTP	90701		N/A
??? (under 7 years old)	907022		N/A
MMR	90707		
OPV	90712		
IPV	90713		
Varicella *	90716		
Td (7 years and older)	90718		
DTP / Hib	90720		N/A
DTaP / Hib	90721		N/A
Hib	90737		N/A
Hepatitis B (child)	90744		N/A
Hepatitis B (adolescent)	90745		
Hepatitis B (adult)	90746	N/A	
Hib/ Hep B	Q0158		N/A

* Varicella is NOT available free for persons age 19 and older.

Name of Person Completing Report (Typed or Printed)

Title

Telephone Number
(   )

AUTHORITY: CHP Contract
COMPLETION: Is Required. Failure to file this report may result in sanctions as permitted under the CHP Contract.

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MSA-127 (9-99)

2000 REPORTING REQUIREMENTS FOR MEDICAID HEALTH PLANS AND HMOs

Report	Product Line	Due Date	Period Covered	Submitted to:	Instructions (Format)	Authority	Focus Area
ANNUAL							
Consolidated Annual Report*	All	3/31/00	Jan 1-Dec 31	CM, LO	Reminder letter and forms	MCL 333.21083 R325.6815 Contract(II-B-4 and II-X)	All areas
HEDIS(R)	C/MC	6/30/00	Jan 1-Dec 31	LO	NCQA	MCL 333.21083 R325.6815	Quality, Utilization
HEDIS(R)	M	6/30/00 **	Jan 1-Dec 31	CM	98-05 NCQA	Contract (II-X-1)	Quality, Utilization
SEMI-ANNUAL							
Complaint and Grievance	M	1/30/00 7/30/00	July 1-Dec 31 Jan 1-June 30	CM	MSA-131	Contract (II-X-4)	Quality
QUARTERLY							
Financial	All	8/15/00 11/15/00	Apr 1-Jun 30 Jul 1-Sep 30	CM, LO	NAIC INS-317	Contract II-X	Financial
Enrollment Data Inpat Disch Data (lic. HMOs only)	All	6/15/00 9/15/00 12/15/00	Jan 1-Mar 31 Apr 1-Jun 30 Jul 1-Sep 30	LO	12/23/98 J. Griffith memo	R325.6815	Utilization
Utilization	M	1/30/00 4/30/00 7/30/00 10/30/00	Jan 1-Dec31 Jan 1-Mar31 Jan 1-Jun 30 Jan 1-Sep 30	CM	98-05, 98-06	Contract (II-X)	Utilization
MONTHLY							
Financial (shared risk only)	M	30 days after end of month	30 days after end of month	CM	Variable	Contract (II-X-5)	Financial
Claims Processing	M	30 days after end of month	30 days after end of month	CM	MSA-2009	Contract (II-X)	Financial
Encounter Data (as capacity develops)	M	Monthly	Minimum of Monthly	DEG electronically	Encounter Data Submission Manual	Contract (II-X-2)	Quality, Utilization

M = Medicaid, C = Commercial, MC = Medicare   LO = Licensing Officer, CM = Contract Manager

* A single consolidated Annual Report is required from all licensed Health Maintenance Organizations and Medicaid contracted health plans.

The 2000 Annual Report is due 3/30/2001 and will include the following components:

- Summary Annual Report for Subscribers - MCL 333.21085
- Health Plan Profile--MSA-126
- Financial--NAIC, INS-317, Audited Financial Statements
- Complaint & Grievance--MSA-131
- Litigation--MSA-129 (limited to litigation directly naming health plan)
- Annual Report of Enrollment--MSA-130 (licensed HMOs only)
- Enrollment by Line of Business--MSA-2005 (licensed HMOs only)
- Inpatient Discharge Data--MSA-2006 (licensed HMOs only)
- Abortion--MSA-128
- Vaccines--MSA-127
- Physician Incentive Program (PIP) Reporting--HCFA annual update format
- Provider Directory
- Certificate of Coverage
- Member Handbook

**Refer to January 20, 2000 letter from Richard Murdock for additional details about 1999 Medicaid HEDIS filing instructions.

[GRAPHIC APPEARS HERE]

ATTACHMENT A

CONTRACTOR'S AWARDED PRICES

[GRAPHIC APPEARS HERE]

ATTACHMENT A
Molina Healthcare of Michigan, Inc.
dba Molina Healthcare of Michigan
AWARDED PRICES

	AFDC	ABAD	OAA	Maternity
Region I				
Wayne				
Region II				
No approved counties				
Region III				
No approved counties				
Region IV				
Ionia	[*]	[*]	[*]	[*]
Kent	[*]	[*]	[*]	[*]
Lake	[*]	[*]	[*]	[*]
Manistee	[*]	[*]	[*]	[*]
Mason	[*]	[*]	[*]	[*]
Mecosta	[*]	[*]	[*]	[*]
Missaukee	[*]	[*]	[*]	[*]
Montcalm	[*]	[*]	[*]	[*]
Muskegon	[*]	[*]	[*]	[*]
Newaygo	[*]	[*]	[*]	[*]
Oceana	[*]	[*]	[*]	[*]
Ottawa	[*]	[*]	[*]	[*]
Wexford	[*]	[*]	[*]	[*]
Region V				
No approved counties				
Region VI				
No approved counties				
Region VII				
Alpena	[*]	[*]	[*]	[*]
Arenac	[*]	[*]	[*]	[*]
Bay	[*]	[*]	[*]	[*]
Crawford	[*]	[*]	[*]	[*]
Gladwin	[*]	[*]	[*]	[*]
Gratiot	[*]	[*]	[*]	[*]
Huron	[*]	[*]	[*]	[*]

[GRAPHIC APPEARS HERE]

ATTACHMENT A
Molina Healthcare of Michigan, Inc.
dba Molina Healthcare of Michigan - continued
AWARDED PRICES

Region VII--continued				
Iosco	[*]	[*]	[*]	[*]
Midland	[*]	[*]	[*]	[*]
Montmorency	[*]	[*]	[*]	[*]
Ogemaw	[*]	[*]	[*]	[*]
Oscoda	[*]	[*]	[*]	[*]
Otsego	[*]	[*]	[*]	[*]
Presque Isle	[*]	[*]	[*]	[*]
Roscommon	[*]	[*]	[*]	[*]
Saginaw	[*]	[*]	[*]	[*]
Sanilac	[*]	[*]	[*]	[*]
Tuscola	[*]	[*]	[*]	[*]
Region VIII				
No approved counties				
Region IX				
Macomb	[*]	[*]	[*]	[*]
Region X				
Oakland	[*]	[*]	[*]	[*]

[GRAPHIC APPEARS HERE]

ATTACHMENT B

APPROVED SERVICE AREAS

[GRAPHIC APPEARS HERE]

ATTACHMENT B
Molina Healthcare of Michigan, Inc.
dba Molina Healthcare of Michigan

Approved Service Area

Region I
Wayne

Region II
No approved counties

Region III
No approved counties

Region IV
Ionia
Kent
Lake
Manistee
Mason
Mecosta
Missaukee
Montcalm
Muskegon
Oceana
Ottawa
Wexford

Region V
No approved counties

Region VI
No approved counties

Region VII
Alpena
Arenac
Bay
Crawford
Gladwin
Gratiot
Huron
Iosco
Midland

[GRAPHIC APPEARS HERE]

ATTACHMENT B-continued
Molina Healthcare of Michigan, Inc.
dba Molina Healthcare of Michigan

Region VII-continued
- Montmorency
- Ogemaw
- Oscoda
- Otsego
- Presque Isle
- Roscommon
- Saginaw
- Sanilac
- Tuscola

Region VIII
- No approved counties

Region IX
- No approved counties

Region X
- No approved counties

[GRAPHIC APPEARS HERE]

ATTACHMENT C

CORRECTIVE ACTION PLANS
(to be developed at a later date)

Form No. DMB 234 (Rev. 1/96)
AUTHORITY: Act 431 of 1984
COMPLETION: Required
PENALTY: Contract will not be executed unless form is filed

STATE OF MICHIGAN
DEPARTMENT OF MANAGEMENT AND BUDGET
OFFICE OF PURCHASING
P.O. BOX 30026, LANSING, MI 48909
OR
530 W. ALLEGAN, LANSING, MI 48933

CONTRACT NO. 071B1001026
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF VENDOR
Molina Healthcare of Michigan, Inc.
dba Molina Healthcare of Michigan
43097, Woodward Avenue, Suite 200
Bloomfield Hills, MI 48302

TELEPHONE Michael A. Graham
(248) 454-1070

VENDOR NUMBER/MAIL CODE
(2) 38-3341599 (008)

BUYER (517) 373-2467
/s/ Ray E. Irvine

Ray E. Irvine

Contract Administrator: Rick Murdock
Comprehensive Health Care Program (CHCP) Services for Medicaid Beneficiaries in Selected Michigan Counties -- Department of Community Health

CONTRACT PERIOD: From: October 1, 2000 To: October 1, 2002*

TERMS	SHIPMENT
N/A	N/A

F.O.B.	SHIPPED FROM
N/A	N/A

MINIMUM DELIVERY REQUIREMENTS
*Plus three (3) each possible one-year extensions

MISCELLANEOUS INFORMATION:

The terms and conditions of this Contract are those of ITB #07110000251, this Contract Agreement and the vendor's quote dated 5-1-00, and subsequent Best And Final Offer. In the event of any conflicts between the specifications, terms and conditions indicated by the State and those indicated by the vendor, those of the State take precedence.

Estimated Contract Value: The exact dollar value of this contract is unknown; the Contractor will be paid based on actual beneficiary enrollment at the rates (prices) specified in Attachment A to the Contract

THIS IS NOT AN ORDER: This Contract Agreement is awarded on the basis of our inquiry bearing the ITB No.07110000251. A Purchase Order Form will be issued only as the requirements of the State Departments are submitted to the Office of Purchasing. Orders for delivery may be issued directly by the State Departments through the issuance of a Purchase Order Form.

All terms and conditions of the invitation to bid are made a part hereof.

FOR THE VENDOR:	FOR THE STATE:
Molina Healthcare of Michigan, Inc. dba Molina Healthcare of Michigan	/s/ David F. Ancell
Firm Name	Signature
/s/ Michael A. Graham	David F. Ancell
Authorized Agent Signature	Name
Michael A. Graham, Chief Executive Officer	State Purchasing Director
Authorized Agent (Print or Type)	Title
9/28/00	[ILLEGIBLE]
Date	Date

Form No. DMB 234A (Rev. 1/96)
AUTHORITY: Act 431 of 1984
COMPLETION: Required
PENALTY: Failure to deliver in accordance with Contract terms and conditions and this notice, may be considered in default of Contract

STATE OF MICHIGAN
DEPARTMENT OF MANAGEMENT AND BUDGET   January 19, 2001
OFFICE OF PURCHASING
P.O. BOX 30026, LANSING, MI 48909
OR
530 W. ALLEGAN, LANSING, MI 48933

CHANGE NOTICE NO.2
TO
CONTRACT NO. 071B1001026
BETWEEN
THE STATE OF MICHIGAN
AND

NAME & ADDRESS OF VENDOR	TELEPHONE Michael A. Graham (248) 454-1070
Molina Healthcare of Michigan, Inc. dba Molina Healthcare of Michigan 43097 Woodward Avenue, Suite 200 Bloomfield Hills, MI 48302	VENDOR NUMBER/MAIL CODE (2) 38-3341599 (008)
	BUYER (517) 373-2467 /s/ Ray E. Irvine,
	Ray E. Irvine, C.P.M

Contract Administrator: Rick Murdock
Comprehensive Health Care Program (CHCP) Services for Medicaid Beneficiaries in Selected Michigan Counties -- Department of Community Health

CONTRACT PERIOD: From: October 1, 2000 To: October 1, 2002*

TERMS	SHIPMENT
N/A	N/A
F.O.B.	SHIPPED FROM
N/A	N/A

MINIMUM DELIVERY REQUIREMENTS
*Plus three (3) each possible one-year extensions

NATURE OF CHANGE(S):

The attached three (3) pages of Contract Changes are effective February 1, 2001. A revised contract document incorporating these changes will be distributed by Department of Community Health (DCH) (Mr. Rick Murdock's office) at a later date.

AUTHORITY/REASON:

Request of agency per memo from Rick Murdock dated 1-17-01, and Section I-T (Modification of Contract).

TOTAL ESTIMATED CONTRACT VALUE REMAINS:

The exact dollar value of this contract is unknown; the contractor will be paid based upon actual beneficiary enrollment at the rates (prices) specified in Attachment A to the original Notice of Contract.

CONTRACT CHANGES

(LISTED IN PAGE NUMBER ORDER AS FOUND IN THE CONTRACT)

1. Page vii (Definition section), "Department", delete the word "it" and insert "its".

(Rationale: Clerical Change)

2. Page viii (Definition section), "HMO", delete the words "defined in Michigan Compiled Laws (MCL 333.21005(2)

(Rationale: New State Statue)

3. Page 4, Section I-J, (Contract Invoicing and Payment) Insert the following at the end of the first paragraph:

> "The contractor shall be responsible for billing for the approved maternity case rate consistent with the department's billing requirements."

(Rationale: Technical Change--Language to be consistent with Medicaid Procedures for payment of Maternity Case Rate)

4. Page 16, Section II-D-2, (Multiple Region Service Areas), Delete "IT" from the third sentence, second paragraph, and insert "it".

(Rationale: Clerical Change)

5. Page 23, II-H-2 (Enhanced Services). Delete "nominal" in the second to last line of the page.

(Rationale: Clarifying change as no fee, even "nominal" can be charged under this circumstance)

6. Page 32, II-J-1 (Special Waiver Provisions for the CHCP), In the third line of last of the subsection insert an "e" to "th"

(Rationale: Clerical Change)

7. Page 37, II-M-2-f (Member Services Staff). Delete "Staff" in the Title of the subsection and first line and insert, "Director".
   Page 37, II-M-2-g (Provider Services Staff). Delete "Staff" in the Title of the subsection and first line and insert, "Director".

(Rationale: Clarifying Change and to be consistent with Site Visit Criteria)

8. Page 42, II-M, 6(f),(Provider Contracts) Insert an additional bullet to this subsection to read:
   . Provides for continuity of treatment in the event a provider's participation terminates during the course of a member's treatment by that provider.

(Rationale: Change required in order to be consistent with overall Contract requirements regarding continuity of care)

9. Page 42, II-M, 6(h) (Provider Credentialling), Change phrase in parenthesis from at least every two years to (at least every three years)

   (Rationale: To be comparable to Senate bill 1209, Chapter 35 section 3528(4) language that, A HMO shall obtain primary verification of participating health professionals at least every 3 years. Also NCQA's allowance of three year re-credentialing cycle for all products.

10. Page 44, II-N-1 (Electronic Billing Capacity) make the following changes:

    Delete subsection (a) and re-letter the remaining subsections.

    Delete subsection (b) current language and insert the following as re-lettered (a).

    (a) Be capable of accepting electronic billing for UB 92 (inpatient and outpatient claims) in the Medicare version 050 electronic format.

    Delete subsection (c) current language and insert the following as re-lettered (b):

    (b) Be capable of accepting professional claims electronically using the National Electronic Data Interchange Transaction Set Health Care Claim: Professional 837 (ASC X12N 837, version 3051) format no later than August 1,2001. DCH will publish guidelines describing the electronic format requirements.

(Rationale: To be consistent with current timeframe and requirements)

11. Page 44, II-N-1, (Electronic Billing Capacity). Insert the following language at the end of Subsection (1):

    "The promulgation of Medicaid policy and provider manuals will specify the coding and procedures that will be acceptable. Therefore, a provider should be able to bill a health plan using the same format and coding instructions as that required for the Medicaid Fee for Service program. Health plans may not require providers to complete additional fields on the electronic forms that are not specified under the Medicaid Fee for Service policy and provider manuals.

    The distinction in billing between health plans and the Medicaid Fee for Service program will be limited to requests of additional documentation and identification of services requiring prior authorization. Health plans may require additional documentation, such as medical records, to justify the level of care provided. In addition, health plans may require prior authorization for services for which the Medicaid Fee for Service program does not require prior authorization.

    DCH has published and will update the web-site addresses or e-mail address of health plans. This information will make it more convenient for providers; (including out of network providers) to be aware of and contact respective health plans regarding the documentation, prior authorization issues, and provider appeal processes. The DCH web-site location is: www.mdch.mi.state.us

(Rationale: To be consistent with current instructions regarding uniform billing)

12. Page 45, II-N-4 (Arbitration) Delete the last two paragraphs under this subsection.

(Rationale: To be consistent with the provisions of 2000 PA 187 and the guidelines established by the Insurance Commissioner)

13. Page 50, II-Q, (Utilization Management) Insert the following after "policies" in the first bullet: "review decision criteria".

(Rationale: Necessary to assure that Contractors have "written decision criteria" that is used in their utilization management program.)

14. Page 55, Section II-U-1 (Contract Grievance/Complaint Procedure Requirements). Correct the legal citation to read "MCL 500.2213".

(Rationale: Clerical Change)

15. Page 55, Section II-U-3, (State Medicaid Appeal Process) Insert the following at the end of subsection (3):

    The Contractor must include the Medicaid Fair Hearing Process as part of the written internal process for resolution of complaints and grievances as well as including references of the Medicaid Fair Hearing process in the Member Handbook.

(Rationale: To clarify the intent of federal and state procedures and requirements regarding the Medicaid Fair Hearing Process)

16. Page 59, Section II-X, (Data Reporting) delete "E" from the first paragraph, line - 6, and insert "F".

(Rationale: Clerical Change)

17. Page 60, II-X, (Data Reporting) Insert a new category # 5 as follows:
    5. Semi-annual complaint and grievance report

(Rationale: HCFA's Waiver requirement is to maintain the semi-annual complaint/grievance reporting from plans.)

18. Page 61, Section II-AA, (Special Payment Provisions-DCH Processing Inpatient Claims). Insert the following at the end of subsection (1): "Until September 30, 2001 Contractors may elect the above option. After September 30,2001, Contractors will be responsible for inpatient claims payments."

    (Rationale: The DCH will no longer be providing this assistance to Contractors after 9-30-01)

Form No. DMB 234A (Rev. 1/96)
AUTHORITY: Act 431 of 1984
COMPLETION: Required
PENALTY: Failure to deliver in accordance with Contract terms and conditions and this notice, may be considered in default of Contract

STATE OF MICHIGAN
DEPARTMENT OF MANAGEMENT AND BUDGET   February 21, 2001
OFFICE OF PURCHASING
P.O. BOX 30026, LANSING, MI 48909
OR
530 W. ALLEGAN, LANSING, MI 48933

CHANGE NOTICE NO.3
TO
CONTRACT NO. 071B1001026
BETWEEN
THE STATE OF MICHIGAN
AND

NAME & ADDRESS OF VENDOR	TELEPHONE Michael A. Graham (248) 454-1070
Molina Healthcare of Michigan, Inc. dba Molina Healthcare of Michigan 43097, Woodward Avenue, Suite 200 Bloomfield Hills, MI 48302	VENDOR NUMBER/MAIL CODE (2) 38-3341599 (009)
	BUYER (517) 241-1647 /s/ Irene Pena
	Irene Pena

Contract Administrator: Rick Murdock
Comprehensive Health Care Program (CHCP) Services for Medicaid Beneficiaries in Selected Michigan Counties -- Department of Community Health

CONTRACT PERIOD: From: October 1, 2000 To: October 1, 2002*

TERMS	SHIPMENT
N/A	N/A

F.O.B.	SHIPPED FROM
N/A	N/A

MINIMUM DELIVERY REQUIREMENTS
*Plus three (3) each possible one-year extensions

NATURE OF CHANGE:
Please note that the buyer for this contract is now Irene Pena. Also please note change in mail code. Correct mail code for the above address is Mail Code 009.

AUTHORITY/REASON:
DMB/OOP

TOTAL ESTIMATED CONTRACT VALUE REMAINS:
The exact dollar value of this contract is unknown; the contractor will be paid based upon actual beneficiary enrollment at the rates (prices) specified in Attachment A to the original Notice of Contract.

Form No. DMB 234A (Rev. 1/96)
AUTHORITY: Act 431 of 1984
COMPLETION: Required
PENALTY: Failure to deliver in accordance with Contract terms and conditions and this notice, may be considered in default of Contract

STATE OF MICHIGAN
DEPARTMENT OF MANAGEMENT AND BUDGET   November 7, 2001
OFFICE OF PURCHASING
P.O. BOX 30026, LANSING, MI 48909
OR
530 W. ALLEGAN, LANSING, MI 48933

CHANGE NOTICE NO.4
TO
CONTRACT NO. 071B1001026
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF VENDOR	TELEPHONE Michael A. Graham
Molina Healthcare of Michigan, Inc. dba Molina Healthcare of Michigan 43097 Woodward Avenue, Suite 200 Bloomfield Hills, MI 48302	(248) 454-1070
	VENDOR NUMBER/MAIL CODE (2) 38-3341599 (009)
	BUYER (517) 241-1467 /s/ Irene Pena
	Irene Pena

Contract Administrator: Rick Murdock
Comprehensive Health Care Program (CHCP) Services for Medicaid Beneficiaries in Selected Michigan Counties -- Department of Community Health

CONTRACT PERIOD: From: October 1, 2000 To: October 1, 2002*

TERMS	SHIPMENT
N/A	N/A
F.O.B.	SHIPPED FROM
N/A	N/A

MINIMUM DELIVERY REQUIREMENTS
*Plus three (3) each possible one-year extensions

NATURE OF CHANGE(S):

Effective 10/1/01 the attached document is hereby incorporated into this contract.

AUTHORITY/REASON:

Per agency's request from Rick Murdock on 9/27/01 and in accordance with the modification clause

TOTAL ESTIMATED CONTRACT VALUE REMAINS:

The exact dollar value of this contract is unknown; the contractor will be paid based upon actual beneficiary enrollment at the rates (prices) specified in Attachment A to the original Notice of Contract.

HEALTH PLAN CONTRACT CHANGES TO BE EFFECTIVE OCTOBER 1, 2001

PROPOSED HEALTH PLAN CONTRACT CHANGES NOTICES
RFP CONTRACT AWARDED FOR BID #071I0000251

DEFINITIONS

1. Insert on Page vi a new definition, "Abuse" as follows:

   "Abuse" means practices that are inconsistent with sound fiscal, business or medical practices, resulting in unnecessary cost to the Medicaid Program, or reimburse for services that are not medically necessary or fail to meet professionally recognized standards of care."

Rationale: Consistent with the MDCH Medicaid Fraud and Abuse Policy.

2. "Clean Claim", (Page vi). Delete current definition and insert,

   "Clean Claim," means that as defined in MCL 400.111i and the Michigan Office of Financial and Insurance Services Bulletin 2000/09.

Rationale: Consistent with Statutory obligation for Health Plans.

3. "Contractor", (Page vii). Insert:

   "HMO," after "Contractor,"

Rationale: Consistent with use of terms by DCH in policy.

4. Insert on Page viii, a new definition, "Fraud", as follows:

   "Fraud" means the intentional misrepresentation or deception made by a person with the knowledge that the deception or misrepresentation could result in unauthorized benefit to that person or another person."

Rationale: Consistent with the MDCH Medicaid Fraud and Abuse Policy

5. "HCFA", (Page viii). Delete current definition and insert (and reorder with new term):

"CMS". Replace HCFA throughout Contract and replace with CMS

Rationale: Consistent with recent federal name change.

HEALTH PLAN CONTRACT CHANGES TO BE EFFECTIVE OCTOBER 1,2001

SECTION I: CONTRACTUAL SERVICES TERMS AND CONDITIONS

6. Section I-B, (Issuing Office), Page 1. Delete

"Ray Irvine" and insert "Irene Pena".

Rationale: To update formal point of Contact with the Office of Purchasing.

7. Section I-GG, (Year 2000 Software Compliance) Page 12.

Delete entire section.

Rationale: No longer necessary to include in Contract.

SECTION II. WORK STATEMENT

8. Section II-D-2, (Multiple Service Area) Page 17. Delete the following from last sentence of subsection.

"Service area expansion will only be approved in those counties requiring additional capacity as determined by DCH."

Rationale: Current language limits flexibility of DCH to meet changing needs of provider network changes and impact on existing service areas.

9. Section II-D-4, (Contractor Minimum Capacity) Page 17. Delete entire subsection (4).

Rationale: Due to drafting error, this subsection was not able to be implemented and is no longer needed at this time.

10. Section II-E-2 (Medicaid Eligible Groups Who May Voluntarily Enroll in the CHCP), Page 18. Delete the last bullet and insert the following:

- Pregnant women, whose pregnancy is the basis for Medicaid Eligibility and Pregnant women who are in their third trimester of pregnancy

Rationale: To be consistent with State Appropriations Boilerplate direction to the DCH.

11. Section II-G-3, (Enrollment Lock In) Page 20. Delete the paragraph following the last bullet in subsection.

Rationale: Language was inserted to permit additional open enrollment period following FY 01 rebid and is no longer necessary.

12. Section II-G-4, (Rural Area Exception), Page 20. Delete current language of the subsection (4) and insert the following:

"During Fiscal Year 2001/2002, following appropriate federal approval, the DCH will implement a "Rural Area Exception" policy that will permit mandatory enrollment of Medicaid Beneficiaries into a health plan that has service area approval within a county and is the only health plan with service area approval in the respective county. The health plan must provide enrolled Beneficiaries a choice of individual providers and permit out of network referrals if specialist and other providers are not available for appropriate medically necessary services. The DCH will notify Contractors once federal approval has been secured. The DCH will provide notice to Contractors of the effective date of this policy. This policy will only be implemented in counties that are designated as "Rural"."

Rationale: Certain counties of the state can only support one system of provider network. As long as choice is provided for Beneficiaries mandatory enrollment should occur. Implementation will be taken through either amendment to the current waiver for the CHCP program or final rules developed by CMS followed by development of target counties appropriate for this policy and Beneficiary notification

13. Section II-G-11, (Disenrollment Requests Initiated by the Contractor), Page 22. Insert

"medically" after "becomes" in the second line of the first sentence of the paragraph following the last bullet of this subsection.

Section II-G-11, (Disenrollment Requests Initiated by the Contractor), Page 22. Insert the following after "Act" in the second line of the first sentence of the paragraph following the last bullet of this subsection:

"as described in Section II-U-4-cv" (page 56)

Rationale: To clarify that disenrollment related to CSHCS eligibility also requires enrollment into CSHCS.

14. Section II-G-13, (Disenrollment for Cause Initiated by the Enrollee), Page 22. Insert the following before the last sentence of this subsection:

"Beneficiaries must demonstrate that adequate care is not available by providers within the Health Plan's provider network. Further criteria, as necessary, will be developed by DCH."

Rationale: Clarification is needed to protect Beneficiaries yet assure that other resources of the Health Plan are utilized prior to disenrollment and enrollment into another Health Plan.

15. Section II-I-4 (Maternal and Infant Support Services), Page 27. Delete the last paragraph of the subsection.

Rationale: The subsection was drafted for the first RFP in 1996 as transitions were made between FFS and managed care for the MSS/ISS program. The criteria have been met every year.

16. Section II-I-6 (Co-payments) Page 28. Insert the following language at the end of the subsection.

"Subject to the same limitations identified in this subsection, the DCH will permit Co-payments to be implemented by Health Plans outside of the annual open enrollment period if the Health Plan provides notification to all of their Medicaid Enrollees and waives the 12-month lock-in from date of notification to enrollees through 30 days following the effective date of the co-payment. Approval outside of the annual open enrollment period will be permitted only once a year consistent with a DCH developed schedule."

Rationale: The DCH has been requested to consider this provision and is willing to implement within parameters that will require the least disruption to the enrollment procedures and communications.

17. Section II-I-18, (20 Visit Mental Health Outpatient Benefit), Page 32. Insert a new Subsection 18 (and insert a corresponding bullet on the bottom on page 24) to read as follows:

"18. 20 Visit Mental Health Outpatient Benefit.

The Contractor shall provide the 20 Visit Mental Health Outpatient Benefit consistent with the policy and procedures established by Medicaid Policy Bullet (QHP 00-08). Services may be provided through contracts with Community Mental Health Services Program, CMHSP, or through contracts with other appropriate providers within the service area.

Rationale: Language necessary to provide specific linkage between Medicaid policy and this Contract.

18. Section II-L-1, (Administrative and Organizational Criteria), Page 34. Delete the bullet reference to accreditation and insert a new bullet to read:

- Be accredited as a managed care organization by either the National Committee on Quality Assurance, NCQA, or Joint Commission on Accreditation of Health Care Organizations, JCAHO, no later than September 30, 2002 or have a formal NCQA or JCAHO site visit scheduled;

Rationale: Previous language stipulated timeline to seek accreditation and is no longer necessary. Accreditation status will be consideration for renewal or rebidding Contract in October 1, 2002.

19. Section II-L-3, (Provider Network and Health Services Delivery Criteria), Page 34. Insert a new bullet to read:

(The Contractor):

- complies with Medicaid Policy regarding procedures for authorization and reimbursement for out of network providers.

Rationale: A product of the Model Hospital/Health Plan Contract process will be Medicaid policy regarding "non-par" procedures that will assure access to care and reimbursement procedures.

20. Section H-M-6-I, (PCP Standards), Page 43. Insert the following as a new paragraph before the first full paragraph on page 43:

    "The Contractor will permit enrollees to choose a "clinic" as a PCP provided that the provider files submitted to the Enrollment Services Contractor is completed consistent with DCH requirements.

Rationale: Through discussions between DCH and Health Plans at the Enrollment Subcommittee, this arrangement has been developed to respond to Beneficiary requests.

21. Section II-N-7, (Case Rate Payments for Emergency Services), Pages 45-46. Delete the last two sentences of the subsection.

Rationale: The language is no longer necessary as it described how the DCH would implement the policy.

22. Section II-O, (Provider Services (Network and Out of Network), Page 46. Insert a new bullet to read:

(The Contractor will)

- Make its provider policies, procedures and appeal processes available over its website. Updates to the policies and procedures will be available on the website as well as through other media used by the Contractor.

Rationale: Because of numerous out of network services, it is important that non-par providers have access to the individual policies, procedures and provider appeal process. The use of websites provides this accessibility.

23. Section II-P, 2 & 3, (Performance Objectives and Statewide Performance Improvement) Page 48, Delete both subsections and replace with the following as a new subsection (2) and renumber remaining subsections:

2. Annual Performance Improvement Objectives

In addition to its internal Quality Assessment and Performance Improvement Program, the Contractor may be required to participate in statewide focused studies and meet minimum performance objectives.

The DCH will collaborate with the CAC and Contractors to determine priority areas for statewide focused studies and performance improvement initiatives. This will include the establishment of time frames for submission of data and information, and review and approval of the methodologies associated with the focused studies to assure that comparisons among Contractors are possible. The clinical priority areas may vary from one year to the next and will reflect the needs of the population; such as care of children, pregnant women, and persons with special health care needs (e.g. HIV/AIDs).

The Contractor will assess performance for the priority area(s) identified by the CAC as requested by DCH, using measurable indicators. The Contractor must submit data and information for priority area(s) as requested by DCH. The Contractor will address the statewide focused study findings for priority area(s) through its Quality Assessment and Performance Improvement Program and develop performance improvement goals, objectives and activities specific to the Contractor.

DCH will establish and attach annual performance objectives to the Contract, (Attachment D). The Contractor will incorporate any statewide performance improvement objectives, established as a result of a statewide focus study or performance improvement initiative, into the written plan for its Quality Assessment and Performance Improvement Program. DCH will use the results of performance assessments as part of the formula for automatic enrollment assignments.

The CAC may recommend standards of care and related protocols in areas including, but not limited to: family planning, diabetes, asthma, end stage renal disease, AIDS, and maternal and infant support. The Contractor must implement these standards of care and related protocols through its Quality Assessment and Performance Improvement Program if required by DCH.

Rationale: The new language updates the Contract to be consistent with current work with the Clinical Advisory Committee and incorporates references to the Annual Performance Standards that will be part of the Contract as Attachment D.

24. Section II-S-1, (Allowed Marketing Locations/Practices directed at the general population), Page 51. Insert the following bullets at the end of the subsection:
    - Individual Contractor "Health Fair" for Enrollee Members
    - Malls or Commercial retail establishments
    - Community Centers
    - Churches

Section II-S-2, (Prohibited Marketing Locations/Practices which target individual Beneficiaries), Page 51. Delete the following bullets:
- "Individual Contractor "Health Fair",
- Malls or commercial retail establishments,
- Community Centers
- Churches

Rationale: The change is intended to be clarifying language and to be consistent with other parts of the Contract that emphasize health promotion and education. Marketing of health education and health promotion messages and programs are essential programs for patient compliance. Changes in the contract are intended to permit more flexibility in this area.

26. Section II-S, (Marketing), Page 51. Insert the following at the end of the second paragraph:

    "Upon receipt by DCH on a complete file for allowed marketing practices and locations, the DCH will provide a decision to the Contractor within 30 days or the Contractor's request will be deemed approved."

Rationale: Many of the proposed marketing initiatives by Contractors require a prompt response by DCH in order for the Contractor to meet printing or other media schedules.

27. Section II-T.3 (Member Handbook/Provider Directory), Page 53. In the second line of the first paragraph, delete: "five (5)" and insert ten (10).

    Insert a new sentence after the first sentence of the first paragraph to read: "Contractors may select the option of distributing new member packets to each household, provided that the mailing includes individual Health Plan membership cards for each member enrolled in the household."

Rationale: Language intended to provide options for plans to conduct mailings in more cost effective ways.

28. Section II-U-4-b, (Termination of Coverage), Page 56. Insert a period after "newborns" in the fifth line of this subsection and delete the remainder of the subsection.

    Section II-U-4-b 9Termination of Coverage, Page 56. Insert the following after "newborns":

    "During Contract year beginning October 1, 2001, the DCH will initiate a process to prospectively re-enroll Medicaid Beneficiaries with the Contractor who have regained eligibility within 93 days from the date eligibility was lost. Until that process is implemented, the Contractor will remain responsible for medically necessary services provided to Beneficiaries who were retroactively reinstated with the Contractor."

    Section II-U-4-c-viii (c), Page 58. Delete this subsection.

Rationale: Based upon recommendations from the Model Health Plan and Hospital Contract workgroup, the DCH will implement a change in enrollment policy that will eliminate retroactive enrollment when a beneficiary regains eligibility within 93 days--and will re-instate enrollment on a prospective basis into the same health plan. The change will not affect continuity of care issues but will eliminate issues of authorization and coverage decisions made during the retro enrollment period. Since the change will not be implemented on October 1st, it is necessary to retain language governing retro reinstatements until the process or prospective reinstatement is implemented

29. Section II-V, (Contractor on-site reviews), Page 58. Delete last sentence of current paragraph. Insert the following at the end of the section:

    "The DCH shall establish findings of pass, incomplete, fail, or deemed status for each criteria included in the annual site visit and tool used to assess health plan compliance. Findings of incomplete or fail shall require the development of a corrective action plan that will be included each year as Attachment C to this Contract."

Rationale: The language describes current operational procedures of DCH in the conduct of annual site visits and development of findings from such site visits.

30. Section II-W, (Contract Remedies), Page 59. Insert the following bullet at the end of listing of bullets:

    - Performance Standards included at Attachment D to the Contract.

Section II-W, (Contract Remedies), Page 59. Insert the following at the end of the Section:

"The application of Contract Remedies related to the Performance Standards included as Attachment D to the Contract is not intended to be applied during Contract Year 2001/2002 and will not take place until the DCH has provided Contractors with at least 90 days notice."

Rationale: The additional bullet is intended to be consistent with the DCH focus on performance and the inclusion of specific performance measures that will be Attachment D to the Contract.

31. Section II-AA-1, (DCH Processing Inpatient Claims), Page 61. Delete the entire subsection.

Rationale: As HMOs, each of the Contractors is expected to be fully prepared to process all provider claims.

32. Section II-AA-3, (Contractor Performance Bonus), Page 62. Insert the following language at the end of the subsection:

"In establishing the annual performance bonus criteria, the DCH will use the following reports and assessments for the applicable calendar/fiscal year and consult with Contractors:

- External Quality Review, EQR;
- Medicaid HEDIS Report;
- Consumer (enrollee member) survey results;
- Beneficiary hotline summary data for the most current 12 month reporting period;
- Administrative, claims payment, and encounter reporting performance; and
- Current nationally recognized NCQA or JCAHO accreditation status.

Rationale: The intent of the new language is to provide Contractors with the listing of data sources used to determine performance bonus criteria.

33. Section II-BB, (Responsibilities of the DCH), Page 63. Insert an additional bullet to read:

- Provide timely data to Health Plans at least 60 days before the effective date of fee for service pricing or coding changes or DRG changes.

Rationale: Health Plans have contracted with many providers using FFS contracts that obligate the Health Plan to pay at current FFS rates. If changes are

made in FFS or DRGs without timely submission of the same changes to the Health Plan, there is risk that the Health Plan will not be able to honor terms of their provider contract.

33. Section II-CC, (Responsibilities of the Department of Attorney General), Page 63. Delete the heading and language in this section and replace with the following:

II-CC RESPONSIBILITIES OF THE DEPARTMENT OF COMMUNITY HEALTH FOR MEDICAID FRAUD AND ABUSE

The DCH has responsibility and authority to make all fraud and/or abuse referrals to the Office of Attorney General, Health Care Fraud Division. Contractors who have any suspicion or knowledge of fraud and/or abuse within any of the DCH's programs must report directly to the DCH by calling (517) 335-5239 or sending a memo or letter to:

Program Investigations Section
Capitol Commons Center Building
400 S. Pine Street, 6th Floor
Lansing, Michigan 48909

When reporting suspected fraud and/or abuse, the Contractor should provide to the DCH the following information:

- Nature of the Complaint
- The name of the individuals and/or entity involved in the suspected fraud and/or abuse, including their address, phone number and Medicaid identification number, and any other identifying information.

The Contractor shall not attempt to investigate or resolve the reported suspicion, knowledge or action without informing the DCH and must cooperate fully in any investigation by the DCH or Office of Attorney General and any subsequent legal action that may result from such investigation.

Rationale: Language is necessary to be consistent with DCH Policy on Medicaid Fraud and Abuse.

CONTRACT ATTACHMENTS

34. Attachment D (NEW) (Medicaid Managed Care Performance Standards). Include the Performance Standards as a new Attachment D to the Contract.

Rationale: Each contract year, the DCH will establish the critical performance measures against which measurement of performance will be made.

The standards will also be used to develop "benchmark" measurement and minimum standards for continued contract. Incentives and penalties will also be associated with the performance standards.

35. Attachment E (New) (Model Health Plan/Hospital Contract). Include the Model Health Plan/Hospital Contract that has been developed by a workgroup of hospital, health plan and DCH representatives.

Rationale: The Model Health Plan/Hospital Contract is intended to provide standard language for negotiating arrangements for hospital services. Parties will still have to negotiate reimbursement and other arrangements. A Medicaid Policy Bulletin will describe the non-par arrangements.

HEALTH PLAN CONTRACT CHANGES TO BE EFFECTIVE OCTOBER 1, 2001

ATTACHMENT D - PERFORMANCE STANDARDS

PURPOSE: The purpose of the performance standards is to establish an explicit process for the ongoing monitoring of health plan performance in important areas of quality, access, customer services and reporting and to be part of the Contract between the State of Michigan and Contracting Health Plans (Attachment D).

The process is intended to be dynamic and reflect statewide issues that may change on a year-to-year basis. Performance measurement will be shared with Health Plans during FY 02 that will compare performance of each Plan over time, to other health plans, and to industry standards. Because the FY 02 Contract year is the initial year for establishing explicit "performance standards", the full development of this process will not be completed.

Consequently, identification of incentives/remedies, "benchmark" targets for each area, and selection of additional performance areas for subsequent years will be established in consultation with Contracting Plans during FY 02.

Once fully developed, (expected for FY 03), the Performance Standards will reflect the following characteristics:

- Target Areas
- Goals for each Target Area
- Minimum Performance Standard for each Target Area
- Monitoring Intervals, (monthly, quarterly, annual) to be used by DCH
- Source of data that will be used by DCH to monitor the Performance Standards
- Monitoring Trigger(s) that will be used by DCH as an "sentinel" indicating substandard performance that may require intervention or corrective action
- Identification of both incentives and remedies to be used depending on outstanding performance or sub-standard performance

PERFORMANCE AREA	GOAL	INTERIM STANDARD	DATA SOURCE	MONITORING FREQUENCY
. Quality of Care: Childhood Immunization	Fully immunize children who turn two years old during the calendar year.	Combination 1 Rate = 50%	HEDIS report	Annual
. Quality of Care: Prenatal care	Pregnant women receive an initial prenatal care visit in the first trimester or within 42 days of enrollment	>= 55%	HEDIS report	Annual
. Access to care: Well child visits 0-15 months	Children 0-15 months of age receive one or more well child visits during 12 month period	>= 90%	Encounter data	Quarterly (Rolling 12 months)
. Access to care: Well child visits 3-6 years	Children three, four, five, and six old receive one or more well child visits during twelve-month period.	>= 45%	Encounter data	Quarterly (Rolling 12 months)

PERFORMANCE AREA	GOAL	INTERIM STANDARD	DATA SOURCE	MONITORING FREQUENCY
. Customer Services: Provider Choice	Voluntarily enrolled beneficiaries receive provider of choice	90%	Random sample of 30 completed surveys of voluntarily assigned enrollees	Quarterly
. Customer Services: Provider Selection	Auto assigned enrollees receive provider selection information and make PCP selection	75%	Random sample of 30 completed surveys of surveyed auto assigned enrollees	Quarterly
. Customer Services: Complaint and grievance monitoring	Achieve and maintain enrollee satisfaction	Verified complaint rate * 5 per 1000 members per month	Beneficiary hotline	Monthly
. Encounter data reporting	Timely encounter data submission by the 15th of the month	100%	MDCH Data Exchange Gateway (DEG)	Monthly
. Provider File Reporting	Timely provider file submission by the 1st of the month	100%	MI Enrolls	Monthly
. Claims Reporting	Health Plans are compliant with statutory requirements for payment of clean claims within 45 days	100%	Claims report submitted by health plan	Monthly

* less than

ATTACHMENT E

MODEL HOSPITAL/HEALTH PLAN CONTRACT

This agreement ("Agreement") shall be effective as of the __________________ day of ___________________________200_ between______________________________________ ("Health Plan"), a (profit/nonprofit) corporation and Health Maintenance Organization licensed under the laws of the State of Michigan, and _______________________, ("Hospital") a Hospital licensed under the laws of the State of Michigan.

1. OBLIGATIONS OF HOSPITAL

1.1. Provision of Covered Services. Hospital agrees to provide Prior Authorized Medically Necessary Covered Services to Members in the same manner, in accordance with the same standards, and within the same time availability, as provided to its other patients within the existing resources of Hospital, subject to Hospital's compliance with Health Plan's Prior Authorization policies. Hospital shall not, other than for reasons of safety, segregate Members in any way or treat them in a location or manner different from any of its other patients. Hospital shall provide all services required by the Emergency Medical Treatment and Active Labor Act, ("EMTALA") and may do so without Prior Authorization. Hospital shall accept Prior Authorized Medically Necessary Elective Admissions of Members that have been arranged by physicians having admitting privileges at Hospital.

1.2. Non-Discrimination. Hospital shall not unlawfully discriminate in the acceptance or treatment of a Member because of the Member's religion, race, color, national origin, age sex, income level, health status, marital status, disability or such other categories of unlawful discrimination as are or may be defined by federal or state law.

1.3. Non-Covered Services. In the event a Member requests services that are Non-Covered Services, such services may be provided by Hospital at the Member's sole cost and expense. Hospital shall be under no obligation to furnish Non-covered Services to Members. Health Plan is not responsible to pay the costs of any Non-Covered Service. The Hospital must receive a signed agreement from the Member prior to the provision of Non-Covered Services in which the Member states that he/she will assume responsibility for the costs of the Non-Covered Service. Hospital agrees not to charge amounts in excess of its normal and customary charge for such services. In the event Hospital does not obtain a signed release, Hospital shall hold Health Plan and Member harmless from any costs or obligations related to such service. Hospital agrees to cooperate with

Health Plan in resolving any grievances related to the provision of Non-Covered Services

1.4. Verification of Member Eligibility. Hospital shall verify the Medicaid eligibility and Health Plan enrollment status of Members.

1.5. Hospital Admission and Services.

1.5.1. Elective Admissions and Services. All Elective Admissions and Services provided to a Member must have Prior Authorization. Any elective Admission shall be arranged by a physician with admitting privileges at Hospital. Hospital shall have the responsibility to verify Prior Authorization at the time of admission.

1.5.2. Screening and Stabilization. Hospital shall provide all services required by EMTALA, and such services do not require Prior Authorization. Hospital must obtain Prior Authorization for any services provided after Member has been stabilized as provided by EMTALA.

1.5.3. Notification Requirement. Hospital shall notify Health Plan within twenty-four (24) hours of any service provided for an Emergency Medical Condition of a Member (including screening pursuant to EMTALA) regardless of whether Member has been stabilized.

1.5.4. Post-Stabilization Services. In all cases where the treating physician has screened a Member and determined that the Member is stabilized and does not have an Emergency Medical Condition requiring immediate admission and treatment, Hospital must contact Health Plan to obtain Prior Authorization before providing additional services, admitting the Member or referring the Member to other services that the treating physician feels are clinically indicated.

1.5.5. Request for Post Stabilization Services. In seeking Prior Authorization for continuing health services or inpatient hospitalization following stabilization of a Member treated pursuant to EMTALA, Hospital shall provide Health Plan with requested information obtained from the medical screening examination, provided in accordance with EMTALA, and including presenting symptoms, physical findings, current medical status, and current diagnosis.

1.6. Government Agency Access. Hospital shall permit authorized government agencies and their subcontractors to conduct on-site evaluations of Hospital's facilities, offices and records as required by State and Federal laws and regulations. If Health Plan receives such notice, Health Plan shall give Hospital reasonable notice of any agency's plans to conduct a site visit, unless Health Plan is prohibited from providing such notice by law.

1.7. Health Plan Access. Upon reasonable notice from Health Plan, Hospital will allow Health Plan personnel to: (i) inspect Hospital's facilities, offices, and equipment during normal business hours; (ii) inspect and review the medical records of Health Plan Members; and (iii) obtain copies of Members' medical

records and claims records for quality and utilization management and investigations of fraud or abuse. Hospital agrees to furnish copies of the medical and claims records reasonably requested by Health Plan for $____per page.

1.8. Maintenance of License. Hospital shall maintain in good standing all licenses required by state and federal law or regulation and shall maintain certification under Titles XVIII and XIX of the Social Security Act for all services Hospital has agreed to provide pursuant to this Agreement. Hospital shall maintain accreditation of all applicable facilities and services by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) or the American Osteopathic Association (AOA). [Delete this sentence if Hospital is not accredited.]

1.9. Maintenance of Records. Hospital shall maintain all pertinent financial and accounting records and evidence pertaining to the provision Covered Services to Members in accordance with generally accepted accounting principles and other procedures specified by federal or state governments. Hospital shall maintain legible, comprehensive and chronological medical records documenting each episode of service to Members and detailing, as appropriate, history, physical findings, diagnoses and treatment plans. Financial and medical records shall be maintained by Hospital for such times as are or may be required by state and federal law and regulations.

1.10. Insurance. Hospital shall maintain at all times policies of general liability and professional liability insurance or self insurance with minimum limits of liability of One Million ($1,000,000.00) Dollars per occurrence and Three Million ($3,000,000.00) Dollars in annual aggregate covering Hospital, its agents and employees against any claims for damages out of any act or omission by Hospital, its agents and employees during terms of this Agreement. Hospital shall also maintain at all times automobile insurance, unemployment compensation insurance and workers' compensation insurance or self-insurance in accordance with the requirements of applicable federal and state laws and regulations. Upon request, Hospital shall furnish Health Plan with original certificates of insurance evidencing the insurances coverages and riders required.

1.11. Medical Treatment. Hospital agrees that Health Plan shall have no liability for the medical judgment of health care providers employed by or under contract with Hospital.

1.12. Required Disclosures. Hospital shall notify Health Plan in writing within ten (10) days of any of the following events:

1.12.1. Suspension, termination, or cancellation of Hospital's state license, Medicaid certification or Medicare certification;

1.12.2. Failure to maintain insurance coverage or self-insurance as prescribed in Section 1.10;

1.12.3. Loss, Suspension or termination of JACHO or AOA accreditation;

1.12.4. Hospital becomes aware that the license or admitting privileges of a Hospital-Based Physician who is employed by it are terminated or suspended for quality reasons

1.12.5. Any change in assumed name(s) or taxpayer identification number(s) through which Hospital provides services and under which Hospital may submit claims under this Agreement.

1.12.6.

1.13. Hospital Compliance with Health Plan Policies. Hospital agrees to be bound by the Plan Policies under the conditions set forth in section 2.2 and 2.2.1 below.

1.14. PHYSICIAN QUALIFICATIONS.

1.14.1. Hospital Credentialing/Re-Credentialing. Hospital shall cooperate with the credentialing and re-credentialing processes of Health Plan. Hospital represents that its Hospital-Based Physicians are licensed and in good standing to practice medicine in the State of Michigan. Hospital agrees to notify Health Plan of the termination or suspension admitting privileges of any physician known to Hospital to be a Health Plan Participating Physician.

1.14.2. Admitting Physicians. Hospital represents that all physicians providing services at Hospital to Members shall be members of the medical staff of the Hospital in accordance with the Hospital's corporate and medical staff bylaws, policies, procedures, rules and regulations. No physician shall obtain or maintain medical staff membership or clinical privileges at Hospital by virtue of being a Participating Physician with Health Plan. A physician shall not be denied or granted admitting privileges based solely on whether the physician is or is not a Participating Physician.

1.14.3. Hospital-Based Physicians. Hospital represents that it has the full legal power and authority to bind its Hospital-Based Physicians who are employees to the terms and conditions of this Agreement

1.15 Payment Administration. Hospital will cooperate with Health Plan's claims payment administration as set forth in Plan Policies including, but not limited to, coordination of benefits, subrogation, verification of coverage, prior certification and record keeping.

1.16 No Unfair Labor Practices. Hospital represents and warrants that Hospital's name does not appear in the current register of employers failing to correct an unfair labor practice compiled pursuant to Section 2 of 1980 PA 278 as amended, MCL 423.322. Hospital agrees and acknowledges that, pursuant to Section 4 of 1980 PA 278, MCL 423.324, Health Plan may void this Agreement, if subsequent to the effective date of this Agreement, the name of Hospital appears in the register.

1.17 Non-Discriminatory Hiring. In the performance of services pursuant to this Agreement, Hospital agrees not to discriminate against any employee or applicant for employment, with respect to their hire, tenure, terms, conditions or privileges of employment, or any matter directly or indirectly related to employment, because of race, color, religion, national origin, ancestry, age, sex, height, weight, marital status, physical or mental handicap or disability. Further, Hospital agrees to comply with the provisions of the Americans with Disabilities Act of 1990 (42 USC 12101 et seq., and 47 USC 225).

1.18 Quality, Utilization and Risk Management. Hospital agrees to allow Health Plan to perform the review of the admission and continuation of hospitalization of Members and to cooperate with Health Plan's policies and procedures as set forth in Plan Policies for Q/U/RM or any other program of review that may be established to promote high standards of medical care. Hospital agrees to allow a "Utilization Review Coordinator" designated by Health Plan to assist Hospital personnel with discharge planning and utilization review for Members.

1.19 Compliance with Laws and Regulations. In performing its obligations under this Agreement, Hospital shall comply with all applicable laws, rules and regulations.

2. OBLIGATIONS OF HEALTH PLAN

2.1. Prior Authorization. All Hospital Services provided to Members that are not mandated by EMTALA require Prior Authorization by Health Plan pursuant to Plan Policies. Health Plan shall provide twenty-four (24) hour, seven (7) day a week availability for Prior Authorization requests by Hospital for treatment, admission or other services. Hospital shall provide Health Plan with information obtained from the medical screening examination, provided in accordance with EMTALA, and presenting symptoms, physical findings, current medical status, and current diagnosis. Upon receipt of this information, Health Plan shall respond within sixty (60) minutes to a Hospital request for Prior Authorization to treat or admit a Member who is stable and has been evaluated and screened pursuant to the mandates of EMTALA.

2.1.1. Documentation of Prior Authorization Process. Medical information submitted as required in Section 2.1 in support of the Prior Authorization request may be provided orally or in writing. If provided orally, the Health Plan Prior Authorization employee who takes the telephone request from Hospital shall write down or tape record the information provided. Both

Health Plan and Hospital staff will record each other's name and the time of telephone contact. If Health Plan gives Prior Authorization for treatment or admission, Health Plan shall provide Hospital with an authorization number or code.

2.1.2. Authorization Response. Failure of Health Plan to respond to Hospital with approval or denial of Prior Authorization within the time frame set in Section 2.1 shall be deemed as Prior Authorization for Medically Necessary treatment appropriate to the diagnosis presented when seeking Prior Authorization.

2.1.3. Effect of Prior Authorization. Prior Authorization by Health Plan shall not prevent Health Plan from a retrospective evaluation of medical services provided by Hospital pursuant to Plan Policies. Health Plan agrees that the grant of Prior Authorization for Covered Services shall create a rebuttable presumption that Medically Necessary services appropriate to the diagnosis presented at the time of Prior Authorization shall be paid for pursuant to this Agreement. Health Plan shall bear the burden to support denial of payment for Prior Authorized services through the dispute resolution process provided in Agreement.

2.2. Health Plan Policies. Health Plan shall provide Hospital with all Plan Polices upon execution of this Agreement.

2.2.1. Amendments to Health Plan Policies. During the term of this Agreement, Health Plan may implement changes in the Plan Policies as may be required by state or federal law or regulation, Medicaid policy or at its discretion. If changes in the Plan Policies are required due to changes in law, regulation, and policy beyond the control of Health Plan, Health Plan shall provide a minimum of thirty (30) days notice to Hospital prior to implementation unless the required changes are mandated to be implemented in less time. For changes in Plan Policies that are not required by law, regulation or policy, Health Plan shall provide a minimum of (___) days notice to Hospital prior to implementation of such change. If Hospital does not exercise its option to terminate the agreement, Hospital agrees to comply with the amendments.

2.3. Insurance. Health Plan shall maintain at all times managed care errors and omissions liability insurance or self-insurance with minimum coverage of $1,000,000 per occurrence and $3,000,000 annual aggregate, covering Health Plan and its agents and employees against any claims for damage arising directly or indirectly in connection with its activities under this Agreement. Health Plan shall also maintain such amounts of insolvency or stop-loss insurance as may be required by OFIS pursuant to the laws of the State of Michigan pertaining to Health Maintenance Organizations. Additionally, Health Plan shall maintain at all times automobile insurance, unemployment compensation insurance, and workers' compensation insurance or self-insurance in accordance with the requirements of all applicable federal and state laws and regulations. Upon

reasonable request, Health Plan shall furnish Hospital with original certificates of insurance evidencing the insurances coverages and riders required.

2.4. Health Plan Determinations. Health Plan agrees that, provided the information supplied by Hospital is accurate, Hospital shall have no liability for determinations, including without limitation, determinations regarding coverage, Prior Authorization and Medical Necessity, that are made by Health Plan employees or contractors.

2.5. Compliance with Laws and Regulations. Health Plan represents that it is a Health Maintenance Organization licensed under the laws of the State of Michigan, that it has never been suspended, excluded or terminated as a contractor under Medicaid, Medicare, or other state or federal health care program, and that it-operates and will continue to operate in conformity with the statutes and regulations applicable to Medicaid contractors. In performing its obligations under this Agreement, Health Plan shall comply with all laws, rules and regulations of the United States and of the State of Michigan. All health professionals and laboratories providing services under this Contract shall be licensed and/or certified as required by law.

2.6. Quality, Utilization and Risk Management. (Q/U/RM) Health Plan agrees to perform Q/U/RM services required in connection with this Agreement and Plan Policies. Health Plan will reimburse Hospital $_____per page for copying expenses incurred by Hospital in conducting Q/U/RM.

2.7. Information. Health Plan will provide Hospital with the following documents (i) the current Credentialing, Re-Credentialing and Hearing Policy and; (ii) the current Utilization and Quality Management programs and, within a reasonable time after adoption, any changes or amendments; and, (iii) the current grievance procedures and, within a reasonable time after adoption, any changes or amendments; and, (iv), if Hospital bears risk under this Agreement, Hospital quarterly reports measuring actual utilization against utilization targets for Hospital.

2.8. Maintenance of Records. Health Plan shall maintain all pertinent financial and accounting records pertaining to the operation of this Agreement in accordance with generally accepted accounting principles or other procedures specified or accepted by the state or federal government. Health Plan will, from time to time and upon reasonable notice from Hospital, permit Hospital to inspect during regular business hours those financial statements and enrollment records which Health Plan maintains and which pertain to the operation of this Agreement. Health Plan shall maintain financial records for such time period as is or may be required under state or federal law or regulation.

2.9. Member Disputes. Health Plan will notify Hospital of all Member complaints involving Hospital. Health Plan agrees to assist Hospital in resolving disputes with Members.

2.10. Member Identification. Health Plan shall provide for distribution of identification cards to its Members. Each card will include a toll-free number that Hospital may use during normal business hours to check eligibility and enrollment in Health Plan. During non-business hours, eligibility verification and plan membership will be available through the state enrollment broker.

3. PAYMENT FOR SERVICES

3.1. Compensation. Health Plan shall pay for all services required by EMTALA and for Prior Authorized Covered Services that Hospital provides to Members in accordance with the payment rates or schedules set forth in Attachment____ incorporated in this Agreement. Absent an agreement establishing different rates or schedules, Health Plan shall pay Hospital according to the Medicaid Rates as established and published by MDCH. Hospital shall not be paid for Covered Services where Prior Authorization was required under the terms of this Agreement and was not obtained in accordance with Section 2.1 or the Plan Policies.

3.2. Billing. Hospital shall exhaust all other insurance resources which could cover all or part of the costs of services delivered to a Member prior to submitting any bill for services to Health Plan pursuant to this agreement. Hospital shall bill Health Plan for Prior Authorized Covered Services and services provided pursuant to EMTALA.

3.2.1. Electronic Billing. Any electronic billing statement submitted by the Hospital to Health Plan shall include all information required in the UB-92 form, (UB-92 Version 050), including detailed and descriptive medical, service and patient data and identifying information. If the Hospital uses a clearing house for electronic claims processing, the date of receipt by Health Plan will be the date the Health Plan or Health Plan's clearinghouse receives control of the claim from the Hospital's clearinghouse. If the Hospital's clearinghouse returns the claim for incorrect or incomplete information, the billing statement will not be considered received by Health Plan and the time limits for payment will not begin to run until actually received. If both the Hospital and (Health Plan) use the same clearinghouse, the date of receipt by the (Health Plan) will be considered the date on which the clearinghouse has determined pursuant to the contract with the Hospital that all ordered checks and edits are complete.

3.2.2. Billing Submission Deadline. Hospital shall present Health Plan with the billing statement within (________) days from the date of performance of Covered Services to Members. It is acknowledged that situations may necessitate the extension of the (______) day submission deadline and the parties may agree to extend this deadline on a case-by-case basis. Among the justifications for

delaying submission of a claim are, changes in eligibility, coordination of benefits, other third-party payor issues or internal Hospital risk management. Absent an agreement to extend the time for submission of a bill, Health Plan shall have no obligation to pay any bill submitted beyond this (____) day limit.

3.3. Payment. Health Plan shall make payment to Hospital within forty-five (45) days of receipt of a Clean Claim. Hospital shall not resubmit any billing during this 45-day period except in response to a Health Plan request for additional information pursuant to Section 3.4. Health Plan shall pay simple interest at a rate of (____)% per annum on payment amount of any Clean Claim not paid within (____) days.

3.4. Rejected Claims. Health Plan shall provide Hospital with a written request for additional information within thirty (30) days after receipt of an inaccurate or insufficient billing statement. A corrected bill submitted by Hospital pursuant to this section shall reinitiate Section 3.3's time for processing a Clean Claim. A bill rejected after resubmission pursuant to this section shall be referred to the dispute resolution process and will not bear interest unless imposed under the dispute resolution process.

3.5. Adjusted Payments. Health Plan may make an adjusted payment on a submitted claim within forty-five days from the date of receipt where the circumstances do not support the billing criteria for the level of service submitted on the claim. Any adjusted payment shall include a full and complete explanation and remittance advice. Hospital reserves the right to contest any adjustment and pursue any remedies through the dispute resolution processes in this Agreement.

3.6. Recoupment. Health Plan may recoup from, or offset against, amounts owed to Hospital under this Agreement, any payments made by Health Plan to Hospital that are in violation of Medicaid policy, Plan Policies or this Agreement. Hospital has the right to dispute any action by Health Plan to recoup or offset claims pursuant to this section through resort to the Dispute Resolution Procedures of this Agreement.

3.7. Member Hold Harmless. Except for applicable Member co-payments and deductibles provided under Benefit Certificates Hospital shall look only to Health Plan for compensation for Covered Services rendered to a Member and shall accept the payments set forth in this Agreement as payment in full for all Covered Services rendered to a Member. In no event, including but not limited to nonpayment by Health Plan, insolvency of Health Plan or breach of this Agreement, shall Hospital bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, seek deductibles or co-pays from or have any recourse against a Member or persons (other than Health Plan) acting on his/her behalf for Covered Services provided pursuant to this Agreement. Hospital shall give notice to Members regarding any charges for Non-Covered

Services. Notwithstanding the foregoing, Hospital may accept payments from third-party payors (e.g. Blue Cross blue Shield of Michigan, auto insurance, etc.) or others who are legally responsible for payment of a Member's medical bill. This Section shall survive termination of this Agreement, regardless of the cause of termination and shall be construed to be for the benefit of Members. Hospital further agrees that this Section supersedes any oral or written agreement hereafter entered into between Hospital and Member or persons acting on the Member's behalf insofar as such agreement relates to payment for Covered Services provided under the terms and conditions of this contract. Except as otherwise provided in this Agreement or as required by MDCH Medicaid policies, bulletins and federal law, this Section is not intended to apply to services provided after this contract has been terminated or to Non-Covered Services.

3.8. Third-Party Payors and Coordination of Benefits. In the event that a Member's medical expenses are eligible, in whole or in part, to be paid by any governmental program, other than by Medicaid, or by a public or private insurance or benefit plan (collectively, "third-party payors"), Health Plan shall coordinate primary and secondary payment responsibility with such other third party payors pursuant to federal and state third party liability statutes and regulations including 42 C.F.R. 433.135-139, MCLA: 400.106(l)(b)(ii), MCLA 500.3101 et seq., as amended (Michigan No-Fault Law), and the Michigan Workers' Compensation Disability Act of 1969, as amended. Hospital shall cooperate with Health Plan's efforts to recover such payments or reimbursements.

3.9. Billing Disputes. At least quarterly throughout the term of this Agreement the parties will make a good faith effort to negotiate and resolve all billing disputes. Every bill must be considered in such a quarterly billing resolution conference prior to submission to mediation or arbitration under the provisions of Section 5.2.

3.10. Financial Relationship with Health Plan. Health Plan will not prohibit Hospital from discussing Hospital's financial relationship with Member.

4. TERMINATION

4.1. Term and Renewal. The term of this Agreement is for one (1) year unless, terminated by either party pursuant to this Agreement. The Agreement begins at 12:01 AM on the effective date stated above. This Agreement shall automatically renew on an annual basis unless either party notifies the other in writing ninety (90) days prior to the renewal day of the Party's intention to terminate the Agreement.

4.2. Termination without Cause. After the first six (6) months, this Agreement may be terminated without cause by either party upon written notice given ninety (90) days in advance of such termination.

4.3. Termination for Cause. Either party may terminate this Agreement for a material breach of this Agreement upon written notice given forty-five (45) days in advance of such termination. The failure of Health Plan to make payments required under this Agreement may be deemed to be a material breach. The failure of Hospital to comply with the policies and procedures of the Plan Policies may be deemed a material breach. In the event of notification of intent to terminate with cause by either party, the breaching party shall have twenty-one (21) days to cure such breach. Unless the material breach is cured, the 21 day period to cure will not extend termination date.

4.4. Automatic Termination. This Agreement will automatically terminate if any of the following events occur:

- 4.4.1 Suspension or termination for any reason of Health Plan as a Medicaid contractor
- 4.4.1. Health Plan loss of licensure as an HMO.
- 4.4.2. Hospital's state license, Medicare or Medicaid certification or JCAHO or AOA accreditation is revoked, terminated, or suspended.
- 4.4.3. Suspension or termination of Hospital status as a Medicaid Provider.

4.5. Termination due to Material Change in Plan Policies. Pursuant to section 2.2.1 above, Health Plan must notify Hospital of changes in Plan Policies in a timely manner prior to implementation. In the event that Health Plan elects to amend Plan Policies, and such amendment affects Hospital adversely, Hospital shall be entitled to terminate this Agreement. Hospital shall notify Health Plan immediately of its intent to terminate under the section. Termination pursuant to the section shall be effective on the effective date of such amendment but no case less than Fourteen (14) days following such notification of termination pursuant to this section.

4.6. Rights upon Termination. Upon termination of this Agreement, the rights of each party hereunder shall terminate, provided however, that Hospital shall be required to treat Members receiving authorized treatment at the time of termination of this Agreement until Member is discharged. Health Plan shall be required to pay Hospital pursuant to payment terms of this Agreement for all services performed in connection with such treatment. Subject to treatment concerns of the Member including continuity of care involving attending specialists and availability of alternative hospital providers, Health Plan shall use its best efforts to arrange for the reassignment and transfer of Members as soon as possible following the termination of this Agreement.

5. DISPUTE RESOLUTION

5.1. Notice. When either party perceives the existence of a dispute, it shall give written notice to the other party describing the nature of the dispute and a proposed resolution. The parties shall negotiate in good faith in an attempt to

resolve the dispute. Section 5.2 of this Agreement shall not apply to matters relating to Health Plan credentialing, re-credentialing or peer review activities.

5.2. Mediation and Binding Arbitration.

5.2.1. Mediation. If the negotiations required in Section 5.1 fail to resolve the dispute, either party may request mediation under the Rules for Mediation of the Alternative Dispute Resolution Service of the American Health Lawyers Association. If the other party agrees, then both parties shall participate in that mediation. Costs shall be apportioned in accordance with the Rules for Mediation. The legal and administrative costs of the parties shall not be considered costs of mediation subject to apportionment.

5.2.2. Binding Arbitration. If the parties do not mediate or mediation does not resolve the dispute within sixty (60) days of the request for mediation, either party may seek binding arbitration either under the Rules for Arbitration of the Alternative Dispute Resolution Service of the American Health Lawyers Association or though the auspices of MDCH. Both parties must agree to binding arbitration. If MDCH arbitration is chosen, costs shall be shared equally. If the American Health Lawyers Association process is chosen, costs shall be apportioned pursuant to the Rules for Arbitration. The legal and administrative costs of the parties shall in neither case be considered costs of arbitration subject to apportionment. An award entered by the arbitrator shall be final and judgment may be entered on it in accordance with applicable law. A request for binding arbitration is not valid if it is made after the date when the institution of legal or equitable proceedings on the underlying dispute would be barred by the applicable statue of limitations.

5.3. Limitation on Binding Arbitration. The binding arbitration procedures described in Section 5.2.3 above shall not apply to any claims between the parties arising out of third party claims asserting malpractice or professional negligence and the parties are not precluded from asserting claims against each other based on contribution, indemnity, breach of contract, or other legal theories, by way of cross-claim or third-party complaint in any court action commenced by a third party which alleges malpractice or professional negligence against either or both of the parties to this contract.

5.4. MDCH Rapid Dispute Process. Notwithstanding the provisions of Section 5.2, the parties may utilize any dispute resolution process developed and implemented by MDCH. Costs of any such dispute resolution process will be born in accordance with the policies established by MDCH in establishing such a dispute resolution process.

5.5. OFIS Claims Processing Appeals. Notwithstanding the provisions of Section 5.2, disputes involving timely claims processing within the provisions of Public Act 187 of 2000, which amended MCL 400.111a and 400.111b and added MCL

400.111i may be appealed to OFIS. Procedures and requirements of OFIS apply to any appeal under these provisions. OFIS will not entertain appeals of claims which have already been subject to binding arbitration.

6. MISCELLANEOUS PROVISIONS

6.1. Definitions. Attachment A contains definitions of terms utilized throughout this Agreement and is hereby expressly incorporated into and made part of this Agreement.

6.2. Relationship of Parties. The relationship of Hospital to Health Plan is that of an independent contractor. Neither Hospital nor any of its employees shall be considered under the provisions of this Agreement or otherwise as being an employee of Health Plan nor shall Health Plan nor any of its employees be considered under the terms of this Agreement or otherwise as being an employee of Hospital. Each party is solely responsible to meet its own financial obligations to its employees including provision of workers' compensation and unemployment insurance coverage, malpractice and other liability insurance, payment of federal state and local taxes and any other costs or expenses necessary to carry out its obligations under this contract. No work, act, commission or omission of any party, its agents, servants or employees, pursuant to the terms and conditions of this Agreement, shall be construed to make or render any party, its agents, servants or employees, an agent, servant, representative or employee of, or joint venturer with, the other party.

6.3. Treatment Options. Hospital shall not be prohibited from discussing treatment options with Health Plan Members that may not reflect Health Plan's position or may not be covered by Health Plan.

6.4. Advocating on Behalf of Health Plan Members. Hospital shall not be prohibited from advocating on behalf of a Health Plan Member in any grievance or utilization review process or individual authorization process to obtain necessary health care services.

6.5. Orderly Transfer. Hospital agrees, in the event of termination of this Agreement, to cooperate with Health Plan in the orderly transfer of Members being treated or evaluated.

6.6. Accreditation. Both parties agree to cooperate and facilitate the efforts of the other party to obtain and maintain appropriate accreditation from JACHO, AOA, National Committee for Quality Assurance (NCQA), Accreditation Association for Ambulatory Health Care (AAAHC), American Accreditation HealthCare Commission (URAC) or other appropriate accrediting body.

6.7. Confidential Information. The parties agree that the items of information subject to confidentiality under this Agreement are: (i) medical information

relating to individual Members; (ii) the schedule of compensation to be paid to Hospital; (iii) all Q/U/RM documents and peer review information; and, (iv) any financial or utilization information provided by Hospital to Health Plan including charge masters the compensation schedule (if different from Medicaid Rates) set forth in the relevant attachments to this Agreement. Otherwise, all other information, including the general manner by which Hospital is paid under this Agreement and the general terms and conditions of this Agreement, may be shared with Members in the reasonable and prudent judgment of the parties to this Agreement.

6.7.1. Notwithstanding the above designation as confidential, Health Plan may disclose financial or utilization information to third parties as necessary: (i) to satisfy internal quality and utilization requirements; (ii) to share with employees or agents of Health Plan who need to know the information carry out Health Plan's quality and utilization obligations; (iii) to satisfy mandatory governmental or regulatory reporting requirements; (iv) to compare cost, quality and service among providers with whom Health Plan has contracted or intends to contract; (v) for premium setting purposes; (vi) for HEDIS reporting; (vii) for JCAHO, NCQA or other reporting necessary for accreditation purposes; or (viii) to perform any of Health Plan's obligations under this Agreement. Any information disclosed to third parties pursuant to this subsection shall remain confidential and Health Plan shall require third party recipients of such information to maintain confidentiality.

6.7.2. Health Plan shall be permitted to prepare and disclose to a third party a report of Hospital's quality data provided however, that Hospital quality data shall not include any information that identifies an individual Member or an individual Hospital or information that is privileged or confidential under peer review or patient confidentiality state or federal laws. For purposes of this subsection, Hospital's quality data includes, without limitation: (i) utilization data of all contracted Hospitals in the aggregate; (ii) HEDIS data production and performance evaluation; (iii) Member satisfaction data; (iv) overall compliance with JCAHO or other comparable quality standards (i.e., NCQA) and (v) Health Plan's disenrollment data.

6.8. Grievances. Health Plan shall notify Hospital of any and all Member complaints involving Hospital. Hospital shall notify Health Plan of any and all Member complaints received from Members. Hospital and Health Plan shall make good faith efforts to investigate complaints and work together to resolve Member complaints in a fair and equitable manner. Hospital shall participate in and cooperate with the Health Plan grievance procedure and comply with final determinations provided in accordance with that procedure. A copy of the Health Plan grievance procedure shall be provided to a Member at the time of enrollment and to Hospital upon execution of this Agreement. This provision shall survive termination of this contract.

6.9. Ownership of Medical Records. All medical records shall belong to Hospital. The release, disclosure, removal or transfer of such records shall be governed by state and federal law and the parties established policies and procedures. Hospital agrees to make a Member's medical records available to Health Plan for purposes of assessing quality of care, conducting medical care evaluations and audits and determining on a concurrent basis the medical necessity and appropriateness of care provided to Health Plan Members. Hospital also agrees to make Member medical records available to appropriate state and federal authorities and their agents for purposes of assessing quality of care or investigating Member grievances. Hospital agrees to comply with all applicable state laws and administrative rules and federal laws and regulations related to privacy and confidentiality of medical records.

6.10. Indemnification by Health Plan. At all times during the term of this Agreement, Health Plan shall indemnify, defend and hold harmless Hospital, its officers, directors, employees, and/or agents from and against all claims, damages, causes of action, cost or expense, including court costs and reasonable attorney's fees, to the extent the liabilities and damages are the result of the sole negligence or other wrongful conduct by Health Plan, its agents and/or employees, arising from this contract.

6.11. Indemnification by Hospital. At all times during the term of this Agreement, Hospital shall indemnify, defend and hold harmless Health Plan, its officers, directors, employees and/or agents against all claims, damages, causes of action, cost or expense, including court costs and reasonable attorney's fees, to the extent that the liabilities and damages are the result of the sole negligence or other wrongful conduct by Hospital, its agents and/or employees, arising from this contract.

6.12. Indemnification for Peer Review. Health Plan will indemnify and hold Hospital harmless against any and all liability or loss, including costs and expenses of defending any such claim, arising from Hospital's participation in Health Plan's peer review.

[Sections 6.9, 6.10, and 6.11 are optional. The decision whether to include them is subject to negotiation between the parties and requires assessment of impact on insurance.]

6.13. Assignment. Neither this Agreement nor any rights or obligations hereunder shall be assignable by either party without the prior written consent of the other party, nor shall the duties imposed herein upon either party be subcontracted or delegated without the prior written approval of the other party.

6.14. Entire Agreement. This Agreement (including attachments) and the Plan Policies contain the entire agreement between the parties with respect to the subject matter of this Agreement. If a conflict develops between this Agreement

and the Plan Policies, Plan Policies shall take precedence. Neither Hospital nor Health Plan shall be subject to any requirements other than as set forth in this Agreement or the Plan Polices. The failure of a party to insist on the strict performance of any condition, promise, agreement or undertaking set forth herein shall not be construed as a waiver or relinquishment of the right to insist upon strict performance of the same condition, promise, agreement or undertaking at a future time.

6.15. Severability. If any provision of this Agreement or portion is declared invalid or unenforceable, the remaining provisions shall nevertheless remain in full force and effect.

6.16. Notices. Any notice required to be given pursuant to the terms and provisions of this Agreement may be sent by first class mail, facsimile, or by certified mail, return receipt requested, postage prepaid, to the following parties: Health Plan Designated Party and Address____ Hospital Designated Party and Address ____.

6.17. Controlling Law. This Agreement shall be construed and enforced in accordance with the laws of the State of Michigan.

6.18. Marketing. Each party to this Agreement specifically authorizes the other party to include it in any and all marketing and advertising materials. Each will provide the other copies of any written marketing materials referencing the other. The parties further acknowledge that this Agreement may be terminated and agree to hold the other harmless for any continued use of marketing materials if such materials were prepared before the receipt of a notice of termination. The parties shall hold each other harmless from reliance upon inaccurate or incomplete information provided by the other in such materials. Except for purposes encompassed by this Section, neither party may utilize the trademarks or service marks of the other party without the express written approval of the other party.

6.19. Limitation of Third Party Rights. This Agreement is intended solely for the benefit of the parties, and is not intended to create any rights or benefits, either express or implied, in any other person, including, without limitation, patients of Hospital, Hospital's successors or assigns. Health Plan may not subcontract or resell any rights to Hospital access or prices created by this Agreement to any third party without the express written approval of Hospital.

6.20. Regulatory Approval. The parties acknowledge and agree that this Agreement may be subject to approval by OFIS.

6.21. Mutual Cooperation. To the extent a conflict of interest is not created hereby each party shall cooperate with the other with respect to any action, suit or

proceeding commenced against either party by a person or entity not a party hereto with respect to the subject matter thereof.

Signed _________________________ Date _________________________

Signed _________________________ Date _________________________

HEALTH PLAN CONTRACT CHANGES TO BE EFFECTIVE OCTOBER 1, 2001

ATTACHMENT A. DEFINITIONS.

The following definitions apply to the entire contract and all attachments.

1) Benefits Certificate means the written document approved by the Division of Insurance, as issued to the Member, which explains the scope of benefits, limitations of coverage and exclusions governing the Member's health care benefit coverage pursuant to the Health Plan's Medicaid Contract with the State of Michigan. Health Plan represents that the Benefit Certificate includes at a minimum all required services as defined by (i) Section 400.105 of the Michigan Compiled Laws; (ii) title XIS of the federal Social Security Act, 42 USC 1936 et seq; (iii) MDCH Program Manuals and Bulletins; (iv) the Comprehensive Health Care Program Contractor agreement between Health Plan and the State of Michigan.

2) Clean Claim means a claim as defined in OFIS Bulletin 2000-09 as follows:

(a) Is submitted within the time frame required under this Agreement;
(b) identifies the name and appropriate tax identification number of the health professional or the health facility that provided treatment or service and includes a matching provider ID number assigned by Health Plan;
(c) identifies the patient (member ID number assigned by Health Plan, address, and date of birth);
(d) identifies Health Plan (Health Plan name and/or ID number)
(e) lists the date (m/d/y) and place of service;
(f) is for covered service (Services must be described using uniform billing coding and instructions (ANSI X12 837) and ICD-9-CM diagnosis. Claims submitted solely for the purpose of determining if a service is covered are not considered clean claims.)
(g) if necessary, substantiates the medical necessity and appropriateness of the care or services provided, that includes any applicable authorization number if prior authorization is required by Health Plan;
(h) includes additional documentation based upon services rendered as reasonably required by Plan Policies;
(i) is certified by Hospital that the claim is true, accurate, prepared with the knowledge and consent of Hospital, and does not contain untrue, misleading, or deceptive information, that identifies each attending, referring, or prescribing physician, dentist, or other practitioner by means of a program identification number on each claim or adjustment of a claim;
(j) is a claim for which Hospital has verified the member's Medicaid eligibility and enrollment in Health Plan before the claim was submitted;
(k) is not a duplicate of a claim submitted within 45 days of the previous submission;

(l) is submitted in compliance with all of Health Plan's prior authorization and claims submission guidelines and procedures;
(m) is a claim for which Hospital has exhausted all known other insurance resources;
(n) is submitted electronically if Hospital has the ability to submit claims electronically
(o) uses the data elements of UB92, (UB92 Version 050), as appropriate.

3) Co-Payment means the predetermined amount a Member must pay, whether stated as a percentage or a fixed dollar, to receive a specific service or benefit.

4) Covered Services means those health care services that Health Plan has committed to provide to Members under the Benefit Certificate

5) Credentialing and Re-Credentialing means the policy that Health Plan will follow in credentialing a new applicant in providing Covered Services and recredentialing every two years.

6) Elective Admissions and Services means all health services not necessary to evaluate, screen and stabilize an Emergency Medical Condition as required by the Emergency Medical Treatment and Active Labor Act, 42 USC 1395dd ("EMTALA").

7) Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent lay person, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (i) serious jeopardy to the health of the individual or in the case of a pregnant woman, the health of the woman or her unborn child; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part.

8) Hospital-Based Physician means a licensed physician employed by the Hospital or under contract with the Hospital for the provision of professional medical services to patients of the Hospital, including, without limitation, radiologists, anesthesiologists, pathologists, and emergency room physicians.

9) Hospital Services means Covered Services customarily provided by a hospital including, without limitation, inpatient services, outpatient services and emergency services, treatment and supplies.

10) Inpatient Services means all Hospital Services that a Hospital provides to a Member who is admitted to Hospital for a period twenty-four (24) hours or more. This term shall not include any professional component of the services, or any personal, non-medical expenses incurred by Member.

11) MDCH means the Michigan Department of Community Health.

12) MDCH/Health Plan Agreement means the agreement between the State of Michigan and Health Plan pursuant to which Health Plan agrees to arrange for the delivery of Covered Services to Members.

13) Medicaid Rates means the entire amount payable by MDCH to Hospitals for covered medical services provided to Medicaid beneficiaries who are not enrolled in health plan pursuant to an MDCH/Health Plan Agreement. It includes, without limitation, Diagnosis Related Group (DRG) payments, Per Diem payments for exempt units, outpatient fee screen payments and applicable Pass-Through payments. The amount payable is reduced by any other available resource such as Medicare, other insurance or a beneficiary's patient pay amount or spend down amount required to be collected by the Hospital.

14) Medical Director means the individual designated by Health Plan to act as its Medical Director.

15) Medically Necessary or Medical Necessity means health care services which are all of the following:

    a) appropriate and necessary for the diagnosis or treatment of a medical condition;
    b) provided for the diagnosis or direct care and treatment of a medical condition;
    c) within the standards of good and accepted medical practice within the established medical community;
    d) not primarily for the convenience of the Member, the Member's physician or another health care provider;
    e) the most appropriate level of service which can be provided safely.

16) Member means a Medicaid beneficiary who is enrolled in the Health Plan.

17) Non-Covered Service means health services that (i) are not included in the definition of Covered Services, or (ii) are services provided before an individual becomes a Member or after an individual ceases to be enrolled as a Member of Health Plan or, (iii) services not required by EMTALA for which Hospital did not secure Prior Authorization.

18) OFIS means the Office of Financial and Insurance Services in the Michigan Department of Consumer and Industry Services.

19) Outpatient Services means all Covered Services other than Inpatient Services.

20) Participating Physician means a duly licensed physician by the State of Michigan who has individually agreed or is an employee, independent contractor or member of a professional service corporation that has agreed to provide Covered Services

for Members on behalf of Health Plan pursuant to a contract or agreement with Health Plan.

21) Participating Provider means a health care provider, including individuals, organizations and facilities, who/which have entered into agreements with Health Plan to provide Covered Services to Members. A Participating Physician is also a Participating Provider.

22) Plan Policies refers not only to documents so titled by Health Plan but also to Health Plan Provider Manual, Health Plan Formulary, procedures, and guidelines developed by Health Plan which address matters such as verification of eligibility, coordination of benefits, transfer policies, quality management, utilization management, peer review and Medicaid Member grievance procedures, standards, bulletins and subsequent additions, revisions and deletions.

23) Physician Services mean Covered Services provided by a physician and include primary care and specialty care services.

24) Health Plan means the Medicaid managed care plan, which is part of the MDCH program to provide medical assistance established by Section 105 of Act No.280 of the Public Acts of 1939, as amended, being 400.105 et seq. of the Michigan Compiled Laws and Title XIX of the federal Social Security Act, 42 U.S.C. 1396 et seq. and the Medicaid Contract between Health Plan and the State of Michigan.

25) Primary Care Physician (PCP) means a physician who has the responsibility for providing initial and primary care to and for managing the total patient care of Members. A Primary Care Physician may be a general practitioner, internist, pediatrician, family practitioner or obstetrician/gynecologist.

26) Prior Authorization or Authorized refers to Hospital securing the approval of Health Plan before delivery to provide non-emergency services to a Member. The standards governing prior authorization and the procedure for obtaining are delineated in Plan Policies.

27) Utilization and Quality Management means the prospective, concurrent, and retrospective utilization management and quality management that Health Plan applies to Covered Services.

END

Form No. DMB 234A (Rev. 1/96) [SEAL]
AUTHORITY: Act 431 of 1984
COMPLETION: Required
PENALTY: Failure to deliver in accordance with contract terms and conditions and this notice, may be considered in default of Contract

STATE OF MICHIGAN
DEPARTMENT OF MANAGEMENT AND BUDGET April 30, 2002
ACQUISITION SERVICES
P.O. BOX 30026, LANSING, MI 48909
OR
530 W. ALLEGAN, LANSING, MI 48933

CHANGE NOTICE NO. 5
TO
CONTRACT NO. 071B1001026
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF VENDOR	TELEPHONE Michael A. Graham (248) 454-1070
Molina Healthcare of Michigan, Inc. dba Molina Healthcare of Michigan 43097 Woodward Avenue, Suite 200 Bloomfield Hills, MI 48302	VENDOR NUMBER/MAIL CODE (2) 38-3341599 (009)
	BUYER (517)241-1647 /s/ Irene Pena
	Irene Pena

Contract Administrator. Rick Murdock
Comprehensive Health Care Program (CHCP) Services for Medicaid Beneficiaries in Selected Michigan Counties -- Department of Community Health

---

CONTRACT PERIOD: From: October 1, 2000 To: October 1, 2004

TERMS	SHIPMENT
N/A	N/A
F.O.B.	**SHIPPED FROM**
N/A	N/A

MINIMUM DELIVERY REQUIREMENTS
*Plus three (3) each possible one-year extensions

NATURE OF CHANGE (S):

Effective immediately, the attached list of changes are hereby incorporated into this contract per agency request from Rick Murdock.

TOTAL ESTIMATED CONTRACT VALUE REMAINS:

The exact dollar value of this contract is unknown; the contractor will be paid based upon actual beneficiary enrollment at the rates (prices) specified in Attachment A to the original Notice of Contract.

Proposed Contract Change Notice
Comprehensive Health Care Program
For Contracts Awarded under ITB 17110000251

1. PROPOSED CONTRACT CHANGE NO. 1:

Amend Title Page of Contract, under "Contract Period" by deleting "October 1, 2002" and inserting "October 1, 2004."

Amend Section I-A (Purpose) by deleting the last two sentences and inserting with following:
The term of the Contract shall be effective October 1, 2000 and continue until October 1, 2004. The Contract may be extended for no more than one (1) year extension after September 30, 2004.

Amend Section I-D (Term of Contract) by deleting the first two sentences and inserting the following:
The term of the Contract shall be effective October 1, 2000 and continue until October 1, 2004. The Contract may be extended for no more than one (1) year extension after September 30, 2004.

Rationale: This is the first possible contract extension permitted under the current agreement. The State of Michigan will not be initiating a competitive re-bid for the Comprehensive Health Care Program over the next several years. Therefore, extending the contract for additional two years is requested. The original contract anticipated a possible five year contract if all extensions were used. With implementation of the Contract Change Notice, the Contract will be a total of four years and defers the decision on re-bidding until FY 04/05, unless the final potential extension is implemented at that time.

2. PROPOSED CONTRACT CHANGE NO. 2:

Amend Section I-C, (Contract Administrator) by deleting the current listed "Contract Administrator" and replacing with the following Contract Administrator:
Cheryl Bupp
Manager, Plan Management Section
Comprehensive Health Plan Division
Michigan Department of Community Health
P.O. Box 30479
Lansing, Michigan 48909

Rationale: The change reflects the responsibility of the Ms. Bupp for the day-to-day management of the Contract.

3. PROPOSED CONTRACT CHANGE NO. 3:

Amend Section II-W, (Contract Remedies), by inserting the following at the end of the section:
"The DCH will not apply any Contract Remedy to two Performance Standards listed in Attachment D that address the issue of Customer Services: (Provider Choice and Provider Selection)."

Rationale: The change is to assure Contracting Health Plans that the Performance Standard (Attachment D of the Contract) based "solely on consumer surveys" will not be subject to application of any future Contract Remedy.

CONFIDENTIAL TREATMENT HAS BEEN REQUESTED FOR PORTIONS OF THIS DOCUMENT. PORTIONS FOR WHICH CONFIDENTIAL TREATMENT IS REQUESTED ARE DENOTED BY "[*]". CONFIDENTIAL INFORMATION OMITTED HAS BEEN FILED SEPARATELY WITH THE SECURITIES AND EXCHANGE COMMISSION.

EXHIBIT 10.4

UTAH DEPARTMENT OF HEALTH
288 North 1460 West, Salt Lake City, Utah 84116

CONTRACT

H9920205	006146
Department Log Number	State Contract Number

1. CONTRACT NAME:
   The name of this Contract is HMO-AMERICAN FAMILY CARE.

2. CONTRACTING PARTIES:
   This Contract is between the Utah Department of Health (DEPARTMENT), and American Family Care (CONTRACTOR).

3. CONTRACT PERIOD:
   The service period of this Contract will be July 1, 1999 through June 30, 2004, unless terminated or extended by agreement in accordance with the terms and conditions of this Contract.

4. CONTRACT AMOUNT:
   The Contractor will be paid up to a maximum amount of $ [*] for the Contract period in accordance with the provisions in this Contract. This Contract is funded with 71.61% Federal funds and with 28.39% State funds. The CFDA# is 93.778 and relates to the federal funds provided.

5. CONTRACT INQUIRIES:
   Inquiries regarding this Contract shall be directed to the following individuals:

CONTRACTOR:	AMERICAN FAMILY CARE	DEPARTMENT OF HEALTH
Contact Person:	Brian Monsen	
Business Address:	American Family Care	Program: Managed Health Care
	2120 South 1300 East,	Contact Person: Ed Ewia
	Suite 303	
	Salt Lake City, UT 84106	Phone Number: (801) 538-6505
Phone Number:	(801) 524-2725	

6. REFERENCE TO ATTACHMENTS INCLUDED AS PART OF THIS CONTRACT:
   Attachment A: Utah Department of Health General Provisions
   Attachment B: Special Provisions
   Attachment C: Covered Services
   Attachment D: Quality Assurance & Utilization Management
   Attachment E: Medicaid Enrollment (Table 1), Cost Data (Table 2), Utilization Data (Table 3), Medicaid Malpractice Information (Table 4)
   Attachment F: Rates and Rate-Related Terms
   Attachment G: Quality Assurance Monitoring Plan

7. PROVISIONS INCORPORATED INTO THIS CONTRACT BY REFERENCE, BUT NOT ATTACHED HERETO:
   A. All other governmental laws, rules, regulations, or actions applicable to services provided herein.
   B. If the Contractor has provided the Department with Assurances, then the Department is entering into this agreement based upon the Assurances provided by the Contractor and the Assurances are incorporated by reference.

8. If the Contractor is not a local public procurement unit as defined by the Utah Procurement Code (UCA Section 63-56-5), this Contract must be signed by a representative of the State Division of Finance and the State Division of Purchasing to bind the State and the Department to this Contract.

9. This Contract, its attachments, and all documents incorporated by reference constitute the entire agreement between the parties and supercede all prior negotiations, representations, or agreements, either written or oral between the parties relating to the subject matter of this Contract.

IN WITNESS WHEREOF, the parties sign this Contract.

CONTRACTOR: AMERICAN FAMILY CARE		UTAH DEPARTMENT OF HEALTH	
By: /s/	26 Aug 99	By: /s/	9/16/99
Signature of Authorized Individual	Date	Shari A. Watkins, C.P.A. Director Official of Fiscal Operations	Date
Print Name: Kirk Olsen			
Title: Chief Executive Officer		[SEAL]	10/4/99
		State Finance:	Date
33-0617992			
Federal Tax Identification Number or		/s/	SEP 24 1999

Social Security Number ----------------------- -----------
State Purchasing: Date

ATTACHMENT "A"

UTAH DEPARTMENT OF HEALTH

GENERAL PROVISIONS

I. CONTRACT DEFINITIONS 1

II. AUTHORITY 1

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ATTACHMENT "A"

UTAH DEPARTMENT OF HEALTH GENERAL PROVISIONS

I. CONTRACT DEFINITIONS

The following definitions apply in these general provisions:

"Assign" or "Assignment" means the transfer of all rights and delegation of all duties in the contract to another person.

"Business" means any corporation, partnership, individual, sole proprietorship, joint stock company, joint venture, or any other private legal entity.

"This Contract" means this agreement between the Department and the Contractor, including both the General Provisions and the Special Provisions.

"The Contractor" means the person who delivers the services or goods described in this Contract, other than the state or the Department.

"The Department" means the Utah Department of Health.

"Director" means the Executive Director of the Department or authorized representative.

"Equipment" means capital equipment which costs at least $1,000 and has a useful life of one year or more unless a different definition or amount is set forth in the Special Provisions or specific Department Program policy as described in writing to Contractor.

"Federal law" means the constitution, orders, case law, statutes, rules, and regulations of the federal government.

"General provisions" means those provisions of this Contract which are set forth under the heading "General Provisions."

"Governmental entity" means a federal, state, local, or federally-recognized Indian tribal government, or any subdivision thereof.

"Individual" means a living human being.

"Local health department" means a local health department as defined in Section 26A-1-102, Utah Code Annotated, 1953 as amended (UCA.).

"Non-governmental entity" means privately held non-profit or for profit organization not classified as a "Governmental entity."

"Person" means any governmental entity, business, individual, union, committee, club, other organization, or group of individuals.

"Recipient" means an individual who is eligible for services provided by the Department or by an authorized Contractor of the Department under the terms of this Contract.

"Services" means the furnishing of labor, time, or effort by a Contractor, not involving the delivery of a specific end product other than reports which are merely incidental to the required performance.

"Special provisions" means those provisions of this Contract which are in addition to the General Provisions and which more fully describe the goods or services covered by this Contract.

"State" means the State of Utah.

"State law" means the constitution, orders, case law, statutes, and rules, of the state.

"Subcontract" means any signed agreement between the Contractor and a third party to provide goods or services for which the Contractor is obligated, except purchase orders for standard commercial equipment, products, or services.

"Subcontractor" means the person who performs the services or delivers the goods described in a subcontract.

II. AUTHORITY

1. The Department's authority to enter into this Contract is derived from Chapter 56, Title 63, UCA; Titles 26 and 26A, UCA; and from related statutes.

2. The Contractor represents that it has the institutional, managerial, and financial capability to ensure proper planning, management, and completion of the project or services described in this Contract.

III. MISCELLANEOUS PROVISIONS

1. For reference clarity, as used in these general provisions: "ARTICLE" refers to a major topic designated by capitalized roman numerals; "SECTION" refers to the next lower numbered heading designated by arabic numerals, and "SUBSECTIONS" refers to the next two lower headings designated by lower case letters and lower case roman numerals.
2. If the general provisions and the special provisions of this Contract conflict, the special provisions govern.
3. These provisions distinguish between two Contractor types: Governmental and Non-governmental. Unspecified text applies to both types. Type-specific statements appear in bold print (e.g., Non-governmental entities only).
4. Once signed by the Director and the State Division of Finance, when applicable, and the State Division of Purchasing, when applicable, this Contract becomes effective on the date specified in this Contract. Changes made to the unsigned Contract document shall be initialed by both persons signing this Contract on page one. Changes made to this Contract after the signatures are made on page one may only be made by a separate written amendment signed by persons authorized to amend this Contract.
5. Neither party may enlarge, modify, or reduce the terms, scope of work, or dollar amount in this Contract, except by written amendment as provided in section 4.
6. This Contract and the contracts that incorporate its provisions contain the entire agreement between the Department and the Contractor. Any statements, promises, or inducements made by either party or the agent of either party which are not contained in the written Contract or other contracts are not valid or binding.
7. The Contractor shall comply with all applicable laws regarding federal and state taxes, unemployment insurance, disability insurance, and workers' compensation.
8. The Contractor is an independent Contractor, having no authorization, express or implied, to bind the Department to any agreement, settlement, liability, or understanding whatsoever, and agrees not to perform any acts as agent for the Department unless expressly set forth herein. Compensation stated herein shall be the total amount payable to the Contractor by the Department. The Contractor shall be responsible for the payment of all income tax and social security amounts due as a result of payments received from the Department for these contract services.
9. The Contractor shall maintain all licenses, permits, and authority required to accomplish its obligations under this Contract.
10. The Contractor shall obtain prior written Department approval before purchasing any equipment with contract funds.
11. Notice shall be in writing, directed to the contact person on page one of this Contract, and delivered by certified mail or by hand to the other party's most currently known address. The notice shall be effective when placed in the U.S. mail or hand-delivered.
12. The Department and the Contractor shall attempt to resolve contract disputes through available administrative remedies prior to initiating any court action.
13. This Contract shall be construed and governed by the laws of the State of Utah. The Contractor submits to the jurisdiction of the courts of the State of Utah for any dispute arising out of this Contract or the breach thereof. The proper venue of any legal action arising under this contract shall be in Salt Lake City, Utah.
14. Any court ruling or other binding legal declaration which declares that any provision of this Contract is illegal or void, shall not affect the legality and enforceability of any other provision of this Contract, unless the provisions are mutually dependent.
15. The Contractor agrees to maintain the confidentiality of records that it holds as agent for the Department as required by the Government Records Access and Management Act, Title 63, Chapter 2, UCA and the confidentiality of records requirements of Title 26, UCA.
16. The Contractor agrees to abide by the State of Utah's executive order, dated June 30, 1989, which prohibits

sexual harassment in the workplace.
17. The waiver by either party of any provision, term, covenant or condition of this Contract shall not be deemed to be a waiver of any other provision, covenant or condition of this Contract nor any subsequent breach of the same or any other provision, term, covenant or condition of this Contract.
18. The Contractor agrees to warrant and assume responsibility for each hardware, firmware, and/or software product (hereafter called the product) that it licenses, or sells, to the Department under this Contract. The Contractor acknowledges that the Uniform Commercial Code applies to this Contract. In general, the Contractor warrants that: (1) the product will do what the salesperson said it would do, (2) the product will live up to all specific claims that the manufacturer makes in their advertisements, (3) the product will be suitable for the ordinary purposes for which such product is used, (4) the product will be suitable for any special purposes that the Department has relied on the Contractor's skill or judgement to consider when it advised the Department about the product, especially to ensure year 2000 compatibility and fitness, (5) the product has been properly designed and manufactured, and (6) the product is free of significant defects or unusual problems about which the Department has not been warned. In general, "year 2000 compatibility and fitness" means: (1) the product warranted by the Contractor will not cease to perform before, during, or after the calendar year 2000, (2) the product will not produce abnormal, invalid, and/or incorrect results before, during, or after the calendar year 2000, (3) will include, but not be limited to, date data century recognition, calculations that accommodate same century and multi-century formats, date data values that reflect century, and (4) accurately process date data (including, but not limited to, calculating, comparing, and sequencing) from, into, and between the twentieth and twenty-first centuries, including leap year calculations.

If problems arise, the Contractor will repair or replace (at no charge to the Department) the product whose noncompliance is discovered and made known to the Contractor in writing. If there is a Year 2000 problem, the Contractor agrees to immediately assign senior engineering staff to work continuously until the product problem is corrected, time being of the essence.

The Contractor warrants that it is Year 2000 compliant with respect to all aspects of performing this Contract. The Contractor bears the risk of loss for Year 2000 failures on its behalf, its subcontractors, or agents relevant to the performance of this Contract.

Nothing in this warranty will be construed to limit any rights or remedies the Department may otherwise have under this Contract with respect to defects other than Year 2000 performance.
19. The State of Utah's sales and use tax exemption number is E33399. The tangible personal property or services being purchased are being paid for from State funds and used in the exercise of that entity's essential functions. If the items purchased are construction materials, they will be converted into real property by employees of this government entity, unless otherwise stated in the contract.

IV. UTAH INDOOR CLEAN AIR ACT

The Contractor, for all personnel operating within the State of Utah, shall comply with the Utah Indoor Clean Air Act, Title 26, Chapter 38, UCA, which prohibits smoking in public places.

V. RELATED PARTIES & CONFLICTS OF INTEREST

1. The Contractor may not pay related parties for goods, services, facilities, leases, salaries, wages, professional fees, or the like for contract expenses without the prior written consent of the Department. The Department may consider the payments to the related parties as disallowed expenditures and accordingly adjust the Department's payment to the Contractor for all related party payments made without the Department's consent. As used in this section, "related parties" means any person related to the Contractor by blood, marriage, partnership, common directors or officers, or 10% or greater direct or indirect ownership in a common entity.
2. The Contractor shall comply with the Public Officers' and Employees' Ethics Act, Section 67-16-10, UCA, which prohibits actions that may create or that are actual or potential conflicts of interest. It also provides that "no person shall induce or seek to induce any public officer or public employee to violate any of the provisions of this act." The Contractor represents that none of its officers or employees are officers or employees of the State of Utah,

unless disclosure has been made in accordance with Section 67-16-8, UCA.

VI. OTHER CONTRACTS

1. The Department may perform additional work related to this Contract or award other contracts for such work. The Contractor shall cooperate fully with other contractors, public officers, and public employees in scheduling and coordinating contract work. The Contractor shall give other contractors reasonable opportunity to execute their work and shall not interfere with the scheduled work of other contractors, public officers, and public employees.
2. The Department shall not unreasonably interfere with the Contractor's performance of its obligations under this Contract.

VII. SUBCONTRACTS & ASSIGNMENTS

The Contractor shall not assign this Agreement without the written consent of the Department. The Department agrees that the Contractor may partially subcontract services, provided that the Contractor retains ultimate responsibility for performance of all terms, conditions and provisions of this Agreement. When subcontracting, the Contractor agrees to use written subcontracts that conform with Federal and State laws. The Contractor shall request Department approval for any assignment at least 20 days prior to its effective date.

VIII. FURTHER WARRANTY

The Contractor warrants that (a) all services shall be performed in conformity with the requirements of this Contract by qualified personnel in accordance with generally recognized standards; and (b) all goods or products furnished pursuant to this Contract shall be free from defects and shall conform to contract requirements. For any item that the Department determines does not conform with the warranty, the Department may arrange to have the item repaired or replaced, either by the Contractor or by a third party at the Department's option, at the Contractor's expense.

IX. INFORMATION OWNERSHIP

Except for confidential medical records held by direct care providers, the Department shall own exclusive title to all information gathered, reports developed, and conclusions reached in performance of this Contract. The Contractor may not use, except in meeting its obligations under this Contract, information gathered, reports developed, or conclusions reached in performance of this Contract without the express written consent of the Department.

X. SOFTWARE OWNERSHIP

1. If the Contractor develops or pays to have developed computer software exclusively with funds or proceeds from this Contract to perform its obligations under this Contract, or to perform computerized tasks that it was not previously performing to meet its obligations under this Contract, the computer software shall be exclusively owned by or licensed to the Department. In the case of software owned by the Department, the Department grants to the Contractor a nontransferable, nonexclusive license to use the software in the performance of this Contract. In the case of software licensed to the Department, the Department grants to the Contractor permission to use the software in the performance of this Contract. This license or permission, as the case may be, terminates when the Contractor has completed its work under this Contract.
2. If the Contractor develops or pays to have developed computer software which is an addition to existing software owned by or licensed exclusively with funds or proceeds from this Contract, or to modify software to perform computerized tasks in a manner different than previously performed, to meet its obligations under this Contract, the addition shall be exclusively owned by or licensed to the Department. In the case of software owned by the Department, the Department grants to the Contractor a nontransferable, nonexclusive license to use the software in the performance of this Contract. In the case of software licensed to the Department, the Department grants to the Contractor permission to use the software in the performance of this Contract. This license or permission, as the case may be, terminates when the Contractor has completed its work under this Contract.

3. If the Contractor uses computer software licensed to it which it does not modify or program to handle the specific tasks required by this Contract, then to the extent allowed by the license agreement between the Contractor and the owner of the software, the Contractor grants to the Department a continuing nonexclusive license to use the software, either by the Department or by a different Contractor, to perform work substantially identical to the work performed by the Contractor under this Contract. If the Contractor cannot grant the license as required by this section, then the Contractor shall reveal the input screens, report formats, data structures, linkages, and relations used in performing its obligations under this Contract in such a manner to allow the Department or another contractor to continue the work performed by the Contractor under this Contract.
4. The Contractor shall deliver to the Department a copy of the software or information required by this Article within 90 days after the commencement of this Contract and thereafter immediately upon making a modification to any of the software which is the subject of this Contract.

XI. INFORMATION PRACTICES

1. (Governmental entities only) The Contractor shall establish, maintain, and practice information procedures and controls that comply with Federal and State law. The Contractor assures that any information about an individual that it receives or requests from the Department pursuant to this Contract is necessary to the performance of its duties and functions and that the information will be used only for the purposes set forth in this Contract. The Department shall inform the Contractor of any non-public designation of any information it provides to the Contractor.
2. (Non-governmental entities only) The Contractor shall establish, maintain, and practice information procedures and controls that comply with Federal and State law. The Contractor may not release any information regarding any person from any information provided by the Department, unless the Department first consents in writing to the release.

XII. INDEMNIFICATION

1. (Governmental entities only) It is mutually agreed that each party assumes liability for the negligent or wrongful acts committed by its own agents, officials, or employees, regardless of the source of funding for this Contract. Neither party waives any rights or defenses otherwise available under the Governmental Immunity Act.
2. (Non-governmental entities only) To the extent authorized by law, the Contractor shall indemnify and hold harmless the Department and any of its agents, officers, and employees, from any claims, demands, suits, actions, proceedings, loss, injury, death, and damages of every kind and description, including any attorney's fees and litigation expenses, which may be brought, made against, or incurred by that party on account of loss or damage to any property, or for injuries to or death of any person, caused by, arising directly or indirectly out of, or contributed to in whole or in part, by reason of any alleged act, omission, professional error, fault, mistake, or negligence of the Contractor or its employees, agents, or representatives, or subcontractors or their employees, agents, or representatives, in connection with, incident to, or arising directly or indirectly out of this Contract, or arising out of workers' compensation claims, unemployment, or claims under similar such laws or obligations.

XIII. SUBMISSION OF REPORTS

If the Contractor is a Local Health Department, it shall submit monthly expenditure reports to the Department in a format approved by the Department. All other Contractors shall submit monthly summarized billing statements to the Department. Expenditure reports and billing statements must be submitted to the Department within 20 days following the last day of the month in which the expenditures were incurred or the services provided.

XIV. PAYMENT

1. If a recipient, a recipient's insurance, or any third-party is responsible to pay for services rendered pursuant to this Contract, the Contractor shall bill and collect for the goods or services provided to the recipient. The Department shall reimburse total actual expenditures, less amounts collected as required by this section.
2. Under no circumstances shall the Department authorize payment to the Contractor that exceeds the amount

specified in this Contract without an amendment to the Contract.
3. The Department agrees to make every effort to pay for completed services, and payments are conditioned upon receipt of applicable, accurate, and completed reports prepared by the Contractor and delivered to the Department. The Department may delay or deny payment for final expenditure reports received more than 20 days after the Contractor has satisfied all Contract requirements.

XV. RECORD KEEPING, AUDITS, & INSPECTIONS

1. The Contractor shall use an accrual or a modified accrual basis for reporting annual fiscal data, as required by Generally Accepted Accounting Principles (GAAP). Required monthly or quarterly reports may be reported using a cash basis.
2. The Contractor and any subcontractors shall maintain financial and operation records relating to contract services, requirements, collections, and expenditures in sufficient detail to document all contract fund transactions. The Contractor and any subcontractors shall maintain and make all records necessary and reasonable for a full and complete audit available for audit or inspection during normal business hours or by appointment, until all audits initiated by federal and state auditors are completed, or for a period of four years from the date of termination of this Contract, whichever is longer, or for any period required elsewhere in this Contract.
3. The Contractor shall retain all records which relate to disputes, litigations, claim settlements arising from contract performance, or cost/expense exceptions initiated by the Director, until all disputes, litigations, claims, or exceptions are resolved.
4. The Contractor shall comply with federal and state regulations concerning cost principles, audit requirements, and grant administration requirements, cited in Table 1. Unless specifically exempted in this Contract's special provisions, the Contractor must comply with applicable federal cost principles and grant administration requirements if state funds are received. The Contractor shall also provide the Department with a copy of all reports required by the State Legal Compliance Audit Guide (SLCAG) as defined in Chapter 2, Title 51, UCA. All federal and state principles and requirements cited in Table 1 are available for inspection at the Utah Department of Health during normal business hours. A Contractor who receives $50,000.00 or more in a year from all federal or from all state sources may be subject to federal and state audit requirements. A Contractor who receives $300,000.00 or more per year from federal sources may be subject to the federal single audit requirement. Counties, cities, towns, school districts, and all non-profit corporations that receive 50% or more of their funds from federal, state or local governmental entities are subject to the State of Utah Legal Compliance Audit Guide. Copies of required audit reports shall be sent to the Utah Department of Health, Bureau of Financial Audit, Box 144002, Salt Lake City, Utah 84114-4002.

FEDERAL AND STATE PRINCIPLES AND REQUIREMENTS

Contractor	Cost Principles	Federal Audit Requirements	State Audit Requirements	Grant Admin. Requirements
State or Local Govt. & Indian Tribal Govts.	OMB Circular A-87	OMB Circular A-133	SLCAG	OMB Common Rule
Hospitals	45 CFR 74, App. E	OMB Circular A-133	SLCAG	OMB Common Rule or Circular A-110
College or University	OMB Circular A-21	OMB Circular A-133	SLCAG	OMB Circular A-110
Non-Profit Organization	OMB Circular A-122	OMB Circular A-133	SLCAG	OMB Circular A-110
For-Profit Organization	48 CFR 31	n/a	n/a	OMB Circular A-110

Table 1

XVI. CONTRACT ADMINISTRATION REQUIREMENTS

The Contractor agrees to administer this Contract in compliance with either OMB Common Rule or OMB Circular A-l10 depending upon the legal status of the Contractor as shown in Table 1. Financial management, procurement, and affirmative step requirements specify that:

1. the Contractor must have fiscal control and accounting procedures sufficient to:
   a. permit preparation of reports required by this Contract, and
   b. permit the tracing of funds to a level of expenditures adequate to establish that such funds have not been used in violation of the restrictions and prohibitions of applicable statutes.
2. the Contractor's financial management systems must meet the following standards:
   a. financial reporting. Accurate, current, and complete disclosure of the financial results of financially assisted activities must be made in accordance with the financial reporting requirements of this Contract.
   b. accounting records. The Contractor must maintain records which adequately identify the source and application of funds provided for federally financially-assisted activities. These records must contain information pertaining to the Contract's awards and authorizations, obligations, unobligated balances, assets, liabilities, outlays or expenditures, and income.
   c. internal control. Effective control and accountability must be maintained for all Contract cash, real and personal property, and other assets. The Contractor must adequately safeguard all such property and must assure that it is used solely for authorized purposes.
   d. budget control. Actual expenditures or outlays must be compared with budgeted amounts for the Contract. Financial information must be related to performance or productivity data, including the development of unit cost information whenever appropriate or specifically required in this Contract. If unit cost data are required, estimates based on available documentation will be accepted whenever possible.
3. Federal OMB cost principles, federal agency program regulations, and the terms of grant and subgrant, and contract agreements will be followed in determining the reasonableness, allowability, and allocability of costs.
   a. source documentation. Accounting records must be supported by such source documentation as canceled checks, paid bills, payrolls, time and attendance records, contract and subcontract award documents, etc.
   b. cash management. Procedures for minimizing the time elapsing between the transfer of funds from the U.S. Treasury and disbursement by the Department and the Contractor must be followed whenever advance payment procedures are used.
4. the Contractor shall use its own procurement procedures which reflect applicable State and local laws, rules, and regulations, provided that the procurements conform to applicable Federal law and the standards identified in this Contract.

   a. The Contractor will maintain a contract administration system which ensures that subcontractors perform in accordance with the terms, conditions, and specifications of its contracts or purchase orders.

   b. The Contractor will maintain a written code of standards of conduct governing the performance of its employees engaged in the award and administration of contracts. No employee, officer or agent of the Department or the Contractor shall participate in selection, or in the award or administration of a contract supported by federal funds if a conflict of interest, real or apparent, would be involved. Such a conflict would arise when:
      i. the employee, officer or agent,
      ii. any member of his immediate family,
      iii. his or her partner; or
      iv. an organization which employs, or is about to employ, any of the above, has a financial or other interest in the firm selected for award. The Department's or the Contractor's officer, employees or agents will neither solicit nor accept gratuities, favors or anything of monetary value from contractors, potential contractors, or parties to subagreements. The Department and the Contractor may set minimum rules where the financial interest is not substantial or the gift is

an unsolicited item of nominal intrinsic value. To the extent permitted by State or local law or regulations, such standards or conduct will provide for penalties, sanctions, or other disciplinary actions for violations of such standards by the Department's or the Contractor's officers, employees, or agents, or by subcontractors or their agents.

c. The Contractor's procedures will provide for a review of proposed procurements to avoid purchase of unnecessary or duplicative items. Consideration should be given to consolidating or breaking out procurements to obtain a more economical purchase. Where appropriate, an analysis will be made of lease versus purchase alternatives, and any other appropriate analysis to determine the most economical approach.

d. To foster greater economy and efficiency, the Contractor, if a governmental entity, is encouraged to enter into State and local intergovernmental agreements for procurement or use of common goods and services.

e. If allowed by law, the Contractor is encouraged to use Federal excess and surplus property in lieu of purchasing new equipment and property whenever such use is feasible and reduces project costs.

f. The Contractor may contract only with responsible contractors possessing the ability to perform successfully under the terms and conditions of a proposed procurement.

g. The Contractor shall maintain records sufficient to detail the significant history of a procurement. These records shall include, but are not necessarily limited to the following:

- i. the rationale for the method of procurement,
- ii. selection of contract type,
- iii. contractor selection or rejection, and
- iv. the basis for the contract price.

h. The Contractor may use time and material type contracts only:

- i. after a determination that no other contract is suitable, and
- ii. if the Contract includes a ceiling price that the Contractor exceeds at its own risk.

i. The Contractor alone will be responsible, in accordance with good administrative practice and sound business judgment, for the settlement of all contractual and administrative issues arising out of procurements. These issues include, but are not limited to source evaluation, protests, disputes, and claims. These standards do not relieve the Contractor of any contractual responsibilities under its contracts.

j. The Contractor shall have protest procedures to handle and resolve disputes relating to its procurements and shall in all instances disclose information regarding the protest to the federal funding agency. A protestor must exhaust all administrative remedies with the Department and the Contractor before pursuing a protest with the federal funding agency.

5. the Contractor shall take all necessary affirmative steps to assure that minority firms, women's business enterprises, and labor surplus area firms are used when possible. Affirmative steps shall include:

a. placing qualified small and minority businesses and women's business enterprises on solicitation lists;

b. assuring that small and minority businesses, and women's business enterprises are solicited whenever they are potential sources;

c. dividing total requirements, when economically feasible, into smaller tasks or quantities to permit maximum participation by small and minority business, and women's business enterprises;

d. establishing delivery schedules, where the requirement permits, which encourage participation by small and minority business, and women's business enterprises;

e. using the services and assistance of the Small Business Administration, and the Minority Business Development Agency of the Department of Commerce; and

f. requiring the prime contractor, if subcontracts are to be let, to take the affirmative steps listed in Article XVI, section 5, subsections a - e.

XVII. DEFAULT, TERMINATION, & PAYMENT ADJUSTMENT

1. Each party may terminate this Contract with cause. If the cause for termination is due to the default of a party, the non-defaulting party shall send a notice, which meets the notice requirements of this Contract, citing the default and giving notice to the defaulting party of its intent to terminate. The defaulting party may cure the default within

fifteen days of the notice. If the default is not cured within the fifteen days, the party giving notice may terminate this Contract 45 days from the date of the initial notice of default or at a later date specified in the notice.
2. The Department may terminate this Contract without cause, in advance of the specified termination date, upon 30 days written notice.
3. The Department agrees to use its best efforts to obtain funding for multi-year contracts. If continued funding for this Contract is not appropriated or budgeted at any time throughout the multi-year contract period, the Department may terminate this Contract upon 30 days notice.
4. If funding to the Department is reduced due to an order by the Legislature or the Governor, or is required by federal or state law, the Department may terminate this Contract or proportionately reduce the services and goods due and the amount due from the Department upon 30 days written notice. If the specific funding source for the subject matter of this Contract is reduced, the Department may terminate this Contract or proportionately reduce the services and goods due and the amount due from the Department upon 30 written notice being given to the Contractor.
5. If the Department terminates this Contract, the Department may procure replacement goods or services upon terms and conditions necessary to replace the Contractor's obligations. If the termination is due to the Contractor's failure to perform, and the Department procures replacement goods or services, the Contractor agrees to pay the excess costs associated with obtaining the replacement goods or services.
6. If the Contractor terminates this Contract without cause, the Department may treat the Contractor's action as a default under this Contract.
7. The Department may terminate this Contract if the Contractor becomes debarred, insolvent, files bankruptcy or reorganization proceedings, sells 30% or more of the company's assets or corporate stock, or gives notice of its inability to perform its obligations under this Contract.
8. If the Contractor defaults in any manner in the performance of any obligation under this Contract, or if audit exceptions are identified, the Department may, at its option, either adjust the amount of payment or withhold payment until satisfactory resolution of the default or exception. Default and audit exceptions for which payment may be adjusted or withheld include disallowed expenditures of federal or state funds as a result of the Contractor's failure to comply with federal regulations or state rules. In addition, the Department may withhold amounts due the Contractor under this Contract, any other current contract between the Department and the Contractor, or any future payments due the Contractor to recover the funds. The Department shall notify the Contractor of the Department's action in adjusting the amount of payment or withholding payment. This Contract is executory until such repayment is made.
9. The rights and remedies of the Department enumerated in this article are in addition to any other rights or remedies provided in this Contract or available in law or equity.

XVIII. FEDERAL REQUIREMENTS

The Contractor shall comply with all applicable federal requirements. To the extent that the Department is able, the Department shall give further clarification of federal requirements upon the Contractor's request. If the Contractor is receiving federal funds under this Contract, certain federal requirements apply. The Contractor agrees to comply with the federal requirements to the extent that they are applicable to the subject matter of this Contract and are required by the amount of federal funds involved in this Contract.

1. CIVIL RIGHTS REQUIREMENTS:

a. The Civil Rights Act of 1964, Title VI, provides that no person in the United States shall, on the grounds of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance. The Health and Human Services regulation implementing this requirement is 45 CFR Part 80.
b. The Civil Rights Act of 1964, Title VII, (P.L. 88-352 & 42 U.S.C. Section 2000e) prohibits employers from discriminating against employees on the basis of race, color, religion, national origin, and sex. Title VII applies to employers of fifteen or more employees, and prohibits all discriminatory employment

practices.

c. The Rehabilitation Act of 1973, as amended, section 504, provides that no otherwise qualified handicapped individual in the United States shall, solely by reason of the handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance. The Health and Human Services regulation 45 CFR Part 84 implements this requirement.

d. The Age Discrimination Act of 1975, as amended (42 U.S.C. Sections 6101-6107), prohibits unreasonable discrimination on the basis of age in any program or activity receiving federal financial assistance. The Health and Human Services regulation implementing the provisions of the Age Discrimination Act is 45 CFR Part 91.

e. The Education Amendments of 1972, Title IX, (20 U.S.C. Sections 1681-1683 and 1685-1686), section 901, provides that no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any educational program or activity receiving federal financial assistance. Health and Human Services regulation 45 CFR Part 86 implements this requirement.

f. Executive Order No. 11246, as amended by Executive Order 11375 relates to "Equal Employment Opportunity," (all construction contracts and subcontracts in excess of $10,000.00)

g. Americans with Disabilities Act of 1990, (P.L. 101-336), section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. Section 794), prohibits discrimination on the basis of disability.

h. The Public Health Service Act, as amended, Title VII, section 704 and TITLE VIII, section 855, forbids the extension of federal support for health manpower and nurse training programs authorized under those titles to any entity that discriminates on the basis of sex in the admission of individuals to its training programs. Health and Human Services regulation implementing this requirement is 45 CFR Part 83.

i. The Public Health Service Act, as amended, section 526, provides that drug abusers who are suffering from medical conditions shall not be discriminated against in admission or treatment because of their drug abuse or drug dependence, by any private or public general hospital that receives support in any form from any federally funded program. This prohibition is extended to all outpatient facilities receiving or benefitting from federal financial assistance by 45 CFR Part 84.

j. The Public Health Service Act, as amended, section 522, provides that alcohol abusers and alcoholics who are suffering from medical conditions shall not be discriminated against in admission or treatment, solely because of their alcohol abuse or alcoholism, by any private or public general hospital that receives support in any form from any federally funded program. This prohibition is extended to all outpatient facilities receiving or benefitting from federal financial assistance by 45 CFR Part 84.

2. Confidentiality: The Public Health Service Act, as amended, sections 301(d) and 543, require that certain records be kept confidential except under certain specified circumstances and for specified purposes. Confidential records include records of the identity, diagnosis, prognosis, or treatment of any patient that are maintained in connection with the performance of any activity or program relating to drug abuse prevention, i.e., drug abuse education, training, treatment, or research, or alcoholism or alcohol abuse education, training, treatment, rehabilitation, or research that is directly or indirectly assisted by the federal government. Public Health Service regulations 42 CFR Parts 2 and 2a implement these requirements.

3. Lobbying Restrictions: Lobbying restrictions as required by 31 U.S.C. Section 1352, requires the Contractor to abide by this section and to place it's language in all of it's contracts:

a. No federal funds have been paid or will be paid, by or on behalf of the Contractor, to any person for influencing or attempting to influence an officer or employee of any federal agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

b. If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any federal agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the federal contract, grant, loan, or cooperative agreement, the Contractor shall complete and submit Federal Standard Form LLL, "Disclosure Form to report Lobbying," in accordance with its instructions.

c. The Contractor shall require that the language of this article be included in the award documents for all subcontracts and that subcontractors shall certify and disclose accordingly.

4. Debarment, suspension or other ineligibility: The Contractor must notify the Department in accordance with the notification requirements specified in Article III, section 11 of this Contract if the Contractor has been debarred within the contract period. Debarment regulations are stated in Health and Human Services regulation 45 CFR Part 76.

5. Environmental Impact: The National Environmental Policy Act of 1969 (NEPA) (Public Law 91-190) establishes national policy goals and procedures to protect and enhance the environment. NEPA applies to all federal agencies and requires them to consider the probable environmental consequences of any major federal activity, including activities of other organizations operating with the concurrence or support of a federal agency. This includes grant-supported activities under this Contract if federal funds are involved. Additional environmental requirements include:

a. the institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order 11514;

b. the notification of violating facilities pursuant to Executive Order 11738 (all contracts, subcontracts, and subgrants in excess of $100,000.00);

c. the protection of wetlands pursuant to Executive Order 11990;

d. the evaluation of flood hazards in floodplains in accordance with Executive Order 11988;

e. the assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. Sections 1451 et seq.);

f. the conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. Section 7401 et seq.);

g. the protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523),

h. the protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205) and;

i. the protection of the national wild and scenic rivers system under the Wild and Scenic Rivers Act of 1968 (16 U.S.C. Sections 1271 et seq.).

6. Human Subjects: The Public Health Service Act, section 474(a), implemented by 45 CFR Part 46, requires basic protection for human subjects involved in Public Health Service grant supported research activities. Human subject is defined in the regulation as "a living individual about whom an investigator (whether professional or student) conducting research obtains data through intervention or interaction with the individual or identifiable private information." The regulation extends to the use of human organs, tissues, and body fluids from individually identifiable human subjects as well as to graphic, written, or recorded information derived from individually identifiable human subjects. The regulation also specifies additional protection for certain classes of human research involving fetuses, pregnant women, human in vitro fertilization, and prisoners. However, the regulation exempts certain categories of research involving human subjects which normally involve little or no risk. The exemptions are listed in 45 CFR Part 46.101(b). The protection of human subjects involved in research, development, and related activities is found in P.L. 93-348.

7. Sterilization: Health and Human Services and Public Health Service have established certain limitations on the performance of nonemergency sterilizations by Public Health Service grant-supported programs or projects that are otherwise authorized to perform such sterilizations. Public Health Service has issued regulations that establish safeguards to ensure that such sterilizations are performed on the basis of informed consent and that the

solicitation of consent is not based on the withholding of benefits. These regulations, published at 42 CFR Part 50, Subpart B, apply to the performance of nonemergency sterilizations on persons legally capable of consenting to the sterilization. Federal financial participation is not available for any sterilization procedure performed on an individual who is under the age of 21, legally incapable of consenting to the sterilization, declared mentally incompetent, or is institutionalized.

8. Abortions and Related Medical Services: Federal financial participation is generally not available for the performance of an abortion in a grant-supported health services project. For further information on this subject, consult the regulation at 42 CFR Part 50. Subpart C.

9. Recombinant DNA and Institutional Biosafety Committees: Each institution where research involving recombinant DNA technology is being or will be conducted must establish a standing Biosafety Committee. Requirements for the composition of such a committee are given in Section IV of Guidelines for Research Involving Recombinant DNA Molecules, (49 FR 46266 or latest revision), which also discusses the roles and responsibilities of principal investigators and grantee institutions. Guidelines for Research Involving Recombinant DNA Molecules and Administrative Practices Supplement should be consulted for complete requirements for the conduct of projects involving recombinant DNA technology.

10. Animal Welfare: The Public Health Service Policy on Humane Care and Use of Laboratory Animals By Awardee Institutions requires that applicant organizations establish and maintain appropriate policies and procedures to ensure the humane care and use of live vertebrate animals involved in research activities supported by Public Health Service. This policy implements and supplements the U.S. Government Principles for the Utilization and Care of Vertebrate Animals Used in Testing, Research, and Training and requires that institutions use the Guide for the Care and Use of Laboratory Animals as a basis for developing and implementing an institutional animal care and use program. This policy does not affect applicable State or local laws or regulations which impose more stringent standards for the care and use of laboratory animals. All institutions are required to comply, as applicable, with the Animal Welfare Act as amended (7 U.S.C. 2131 et seq.) and other federal statutes and regulations relating to animals. These documents are available from the Office for Protection from Research Risks (OPRR), National Institutes of Health, Bethesda, MD 20892, (301) 496-7005.

11. Contract Provisions: The Contractor must include the following provisions in its contracts, as limited by the statements enclosed within the parentheses following each provision:

a. administrative, contractual, or legal remedies in instances where contractors violate or breach contract terms, and provides for such sanctions and penalties as may be appropriate. (Contracts other than small purchases. Small purchase involve relatively simple and informal procurement methods that do not cost more than $100,000 in aggregate.)

b. termination for cause and for convenience by the grantee or subgrantee including the manner by which it will be effected and the basis for settlement. (All contracts in excess of $10,000)

c. compliance with Executive Order 11246 of September 24, 1965 entitled "Equal Employment Opportunity," as amended by Executive Order 11375 of October 13, 1967 and as supplemented in Department of Labor regulations (41 CFR Chapter 60). (All construction contracts awarded in excess of $10,000 by the Contractor and its contractors or subgrantees)

d. compliance with the Copeland "Anti-Kickback" Act (18 U.S.C. 874) as supplemented in Department of Labor regulations (29 CFR Part 3). (All contracts and subgrants for construction or repair)

e. compliance with the Davis-Bacon Act (40 U.S.C. 276a to a-7) as supplemented by Department of Labor regulations (29 CFR Part 5). (Construction contracts in excess of $2,000 awarded when required by Federal grant program legislation)

f. compliance with the Contract Work Hours and Safety Standards Act, sections 103 and 107, (40 U.S.C. 327-330) as supplemented by Department of Labor regulations (29 CFR Part 5). (Construction contracts awarded in excess of $2,000, and in excess of $2,500 for other contracts which involve the employment of mechanics or laborers)

g. notice of the federal awarding agency requirements and regulations pertaining to reporting.

h. notice of federal awarding agency requirements and regulations pertaining to patent rights with

respect to any discovery or invention which arises or is developed in the course of or under such contract.

i. federal awarding agency requirements and regulations pertaining to copyrights and rights in data.

j. access by the Department, the Contractor, the Federal funding agency, the Comptroller General of the United States, or any of their duly authorized representatives to any books, documents, papers, and records of the contractor which are directly pertinent to that specific contract for the purpose of making audit, examination, excerpts, and transcriptions.

k. compliance with all applicable standards, orders, or requirements of the Clear Air Act, section 306, (42 U.S.C. 1857(h)), the Clean Water Act, section 508, (33 U.S.C. 1368), Executive Order 11738, and Environmental Protection Agency regulations (40 CFR Part 15). (Contracts, subcontracts, and subgrants of amounts in excess of $100,000)

1. mandatory standards and policies relating to energy efficiency which are contained in the state energy conservation plan issued in compliance with the Energy Policy and Conservation Act (Pub. L. 94-163).

12. (Governmental entities only) Merit System Standards: The Intergovernmental Personnel Act of 1970 (42 U.S.C. Section 4728-4763), requires adherence to prescribed standards for merit systems funded with federal funds.

13. Misconduct in Science: The United States Public Health Service requires certain levels of ethical standards for all PHS grant-supported projects and requires recipient institutions to inquire into, investigate and resolve all instances of alleged or apparent misconduct in science. Issues involving potential criminal violations must be promptly reported to the HHS Office of Inspector General. (See regulations in 42 CFR Part 50, Subpart A)

END OF GENERAL PROVISIONS

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For the purpose of the Contract all article, section, and subsection headings in these Attachments B, C, and D are for convenience in referencing the provisions of the Contract. They are not enforceable as part of the text of the Contract and may not be used to interpret the meaning of the provisions that lie beneath them.

ATTACHMENT B - SPECIAL PROVISIONS

ARTICLE I - DEFINITIONS

For the purpose of the Contract:

A. "Advance Directives" means oral and written instructions about an individual's medical care, in the event the individual is unable to communicate. There are two types of Advance Directives: a living will and a medical power of attorney.

B. "Balance Bill" means the practice of billing patients for charges that exceed the amount that the MCO will pay.

C. "CHEC Eligible" means any Medicaid recipient under the age of 21 who is eligible to receive Early Periodic Screening Diagnostic and Treatment (EPSDT) services in accordance with 42 CFR Part 441, Subpart B.

D. "CHEC Program" or Child Health Evaluation and Care program is Utah's version of the federally mandated Early Periodic Screening, Diagnosis and Treatment (EPSDT) program as defined in 42 CFR Part 441, Subpart B. (See Attachment C, Covered Services, 21.)

E. "Division of Health Care Financing" or "DHCF" means the division within the Department of Health responsible for the administration of the Utah Medicaid program.

F. "Emergency Services" means those services provided in a hospital, clinic, office, or other facility that is equipped to furnish the required care, after the sudden onset of 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 that the absence of immediate medical attention to result in:

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of a woman or her unborn child) in serious jeopardy;

2. Serious impairment to bodily functions; or

3. Serious dysfunction of any bodily organ or part.

G. "Enrollee" means any Medicaid eligible: (1) who, at the time of enrollment resides within the geographical limits of the CONTRACTOR's Service Area; (2) whose name appears on the DEPARTMENT's Eligibility Transmission as a new, reinstate, or retroactive Enrollee; and (3) who is accepted for enrollment by the CONTRACTOR according to the conditions set forth in this Contract excluding residents of the Utah State Hospital, Utah State Developmental Center, and long-term care facilities except as defined in Attachment C.

H. "Enrollment Area" or "Service Area" means the counties enumerated in Article II.

I. "Family Member" means all Medicaid eligibles who are members of the same family living at home.

J. "Home and Community-Based Services" means services, not otherwise furnished under the State's Medicaid plan, that are furnished under a waiver of statutory requirements granted under the provisions of CFR Part 441, subpart G. These services cover an array of Home and Community-Based Services that are cost-effective and necessary for an individual to avoid institutionalization.

K. "Managed Care Organization" or "MCO" means an organization that meets the State Plan's definition of an HMO or prepaid health plan and which provides, either directly or through arrangement with other providers, comprehensive general medical services to Medicaid eligibles on a contractual prepayment basis.

L. "Marketing Material" means materials in all mediums, including member handbooks, brochures and leaflets, newspaper, magazine, radio, television, billboard and yellow pages advertisements, and presentation materials used by marketing representatives. It includes materials mailed to, distributed to, or aimed at Medicaid clients specifically, and any material that mentions "Medicaid," "Medicaid Assistance," or "Title XIX."

M. "Medically Necessary" means any medical service that (a) is reasonably calculated to prevent, diagnose, or cure conditions in the Enrollee that endanger life, cause suffering or pain, cause deformity or malfunction, or threaten to cause a handicap, and (b) there is no equally effective course of treatment available or suitable for the Enrollee requesting the service which is more conservative or substantially less costly. Medical services will be of a quality that meets professionally recognized standards of health care, and will be substantiated by records including evidence of such medical necessity and quality. Those records will be made available to the DEPARTMENT upon request. For CHEC enrollees, "Medically Necessary" means preventive screening services and other medical care, diagnostic services, treatment, and other measures necessary to correct or ameliorate defects and physical and mental illnesses and conditions, even if the services are not included in the Utah State Medicaid Plan.

N. "Member Services" means a method of assisting Enrollees in understanding CONTRACTOR policies and procedures, facilitating referrals to participating specialists, and assisting in the resolution of problems and member complaints. The purpose of Member Services is to improve access to services and promote Enrollee satisfaction.

O. "Physician Incentive Plan" means any compensation between a contracting organization and a physician group that may directly or indirectly have the effect of reducing or limiting services provided with respect to Enrollees in the organization.

P. "Prepaid Mental Health Plan" means the mental health centers that contract with the DEPARTMENT to provide inpatient and outpatient mental health services to Medicaid clients living within each mental health center's jurisdiction.

Q. "Primary Care Provider" or "PCP" means a health care provider the majority of whose practice is devoted to internal medicine, family/general practice or pediatrics. The MCO may allow other specialists to be PCPs, when appropriate. PCPs are responsible for delivering primary care services, coordinating and managing Enrollees' overall health and, authorizing referrals for other necessary care.

R. "Restriction Program" means the Federally mandated program (42 CFR 431.54(e)) for Medicaid clients who over-utilize Medicaid services. If the DEPARTMENT in conjunction with the CONTRACTOR finds that an Enrollee has utilized Medicaid services at a frequency or amount that is not Medically Necessary, as determined in accordance with utilization guidelines adopted by the DEPARTMENT, the DEPARTMENT may place the Enrollee under the Restriction Program for a reasonable period of time to obtain Medicaid services from designated providers only.

S. "State Plan" means the State Plan for organization and operation of the Medicaid program as defined pursuant to Section 1102 of the Social Security Act (42 U.S.C. 1302).

ARTICLE II - SERVICE AREA

The Service Area is limited to the urban counties of Davis, Salt Lake, Utah and Weber.

ARTICLE III - ENROLLMENT, ORIENTATION, MARKETING, AND DISENROLLMENT

A. ENROLLMENT PROCESS

1. ENROLLEE CHOICE

The DEPARTMENT will offer potential Enrollees a choice among all MCOs available in the Enrollment Area. The DEPARTMENT will inform potential Enrollees of Medicaid benefits. The Medicaid client's intent to enroll is established when the applicant selects The CONTRACTOR, either verbally or by signing a choice of health care delivery form or equivalent. This initiates the action to send an advance notification to the CONTRACTOR. Medicaid Enrollees made eligible for a retroactive period prior to the current month are not eligible for CONTRACTOR enrollment during the retroactive period.

2. PERIOD OF ENROLLMENT

Each Enrollee will be enrolled for the period of the Contract or the period of Medicaid eligibility or until such person disenrolls or is disenrolled, whichever is earlier. Until the DEPARTMENT notifies the CONTRACTOR that an Enrollee is no longer Medicaid eligible, the CONTRACTOR may assume that the Enrollee continues to be eligible. Each Enrollee will be automatically re-enrolled at the end of each month unless that Enrollee notifies the DEPARTMENT's Health Program Representative of an intent not to re-enroll in the MCO prior to the benefit issuance date.

3. OPEN ENROLLMENT

The CONTRACTOR will have a continuous open enrollment period that meets the requirements of Section 1301(d) of the Public Health Service Act. The DEPARTMENT will certify, and the CONTRACTOR agrees to accept individuals who are eligible to be enrolled in the MCO under the provisions of this Contract:

a. in the order in which they apply; and

b. without restrictions unless authorized by the DEPARTMENT.

4. NO HEALTH SCREENING

The DEPARTMENT and the CONTRACTOR agree that no potential Enrollee will be pre-screened or selected by either party for enrollment on the basis of pre-existing health problems or on the basis of race, color, national origin, disability or age.

5. INDEPENDENT ENROLLMENT

Each Medicaid eligible can be enrolled or disenrolled in the MCO, independent of any other Family Member's enrollment or disenrollment.

6. REPRESENTATIVE POPULATION

The CONTRACTOR will service a population representative of the categories of eligibility within the area it serves.

7. ELIGIBILITY TRANSMISSION

a. IN GENERAL

Before the close of business of each day, the DEPARTMENT will provide to the CONTRACTOR an Eligibility Transmission which is an electronic file that includes individuals which the DEPARTMENT certifies as Medicaid eligible and who enrolled in the MCO. Eligibility transmissions include new Enrollees, reinstated Enrollees, retroactive Enrollees, deleted Enrollees and Enrollees whose eligibility information results in a change to a critical field. The Eligibility Transmission will be in accordance with the Utah Health Information Network (UHIN) standard. The DEPARTMENT represents and warrants to the CONTRACTOR that the appearance of an individual's name on the Eligibility Transmission, other than a deleted Enrollee, will be conclusive evidence for purposes of this Contract, that such person is enrolled in the program and qualifies for medical assistance under Medicaid Title XIX and that the DEPARTMENT agrees to pay premiums for such Enrollees.

b. NEW ENROLLEES

New Enrollees are enrolled in this MCO until otherwise specified; these Enrollees will not appear on future transmissions unless there is a change in a critical field. Critical fields are coverage dates, recipient name, date of birth, date of death, sex, social security number, case information, address, telephone number, payment code, coordination of benefits, and the Enrollee's provider under the Restriction Program. Enrollees with a spenddown requirement will appear on the eligibility transmission on a month by month basis after the spenddown is met.

c. RETROACTIVE ENROLLEES

Retroactive Enrollees are those who were Enrollees previous to the current month. Retroactive Enrollees include newborn Enrollees or Enrollees who have been reported in one payment category in a previous month but have been changed to a new payment category for that previous month.

d. REINSTATED ENROLLEES

Reinstated Enrollees are those who were enrolled for the previous month and also closed at the end of the previous month. These Enrollees are eligible retroactively to the beginning of the current month.

e. DELETED ENROLLEES

Deleted Enrollees are those who are no longer eligible for Medicaid or who were disenrolled from the MCO.

f. ADVANCED NOTIFICATION TRANSMISSION

An Advanced Notification Transmission is another electronic file (separate from the Eligibility Transmission) that will be sent to the CONTRACTOR when an individual has selected the MCO prior to becoming eligible for Medicaid. These individuals may or may not become eligible for Medicaid. Use of information about such individuals is restricted to providing the individual with an orientation to the MCO prior to the individual's eligibility for Medicaid. The CONTRACTOR is not required to orient individuals until they appear on the Eligibility Transmission.

8. CHANGE OF ENROLLMENT PROCEDURES

The CONTRACTOR will be advised of anticipated changes in DEPARTMENT policies and procedures as they relate to the enrollment process and their comments will be solicited. The CONTRACTOR agrees to be bound by such changes in DEPARTMENT policies and procedures that are mutually agreed upon by the CONTRACTOR and the DEPARTMENT.

B. MEMBER ORIENTATION

1. INITIAL CONTACT - GENERAL ORIENTATION

The CONTRACTOR will make a good faith effort to ensure that each Enrollee or Enrollee's family or guardian receives the CONTRACTOR's member handbook. The CONTRACTOR Representative will make a good faith effort, as evidenced in written or electronic records, to make an initial contact with the Enrollee within 10 working days after the CONTRACTOR has been notified through the Eligibility Transmission of the Enrollee's MCO enrollment. The initial contact will be in person or by telephone (or in writing, but only if reasonable attempts have been made to make the contact in person by telephone) and will inform the Enrollee of the MCO rules and policies. The CONTRACTOR must ensure that Enrollees are provided interpreters, Telecommunication Device for the Deaf (TDD), and other auxiliary aids to ensure that Enrollees understand their rights and responsibilities. During the initial contact the CONTRACTOR Representative will provide, at a minimum, the following information to the Enrollee or potential Enrollee:

a. specific written and oral instructions on the use of the CONTRACTOR's Covered Services and procedures;

b. availability and accessibility of all Covered Services, including the availability of family planning services and that the Enrollee may obtain family planning services from Medicaid providers other than providers affiliated with the CONTRACTOR;

c. the client's rights and responsibilities as an Enrollee of the Health Plan, including the right to file a grievance and how to file a grievance;

d. the right to terminate enrollment with the MCO; and

e. encouragement to make a medical appointment with a CONTRACTOR provider.

2. IDENTIFICATION OF ENROLLEES WITH SPECIAL HEALTH CARE NEEDS

During the initial contact with each Enrollee the CONTRACTOR representative will use a process that will identify children and adults with special health care needs. The CONTRACTOR representative will clearly describe to each Enrollee during the initial contact the process for requesting specialist care. When an Enrollee is identified as having special health care needs, the CONTRACTOR Representative will forward this information to a CONTRACTOR individual with knowledge of coordination of care and services necessary for such Enrollees. The CONTRACTOR individual with knowledge of coordination of care for Enrollees with special health care needs will make a good faith effort to contact Enrollees within ten working days after identification to begin coordination of health care needs, if necessary. The CONTRACTOR will not discriminate on the basis of health status or the need for health care services.

The DEPARTMENT's Health Program Representatives are responsible to forward information, i.e., pink sheets identifying Enrollees with special health care needs and limited language proficiency needs to the CONTRACTOR in a timely way coinciding with the daily Eligibility Transmission as much as possible.

3. INABILITY TO CONTACT ENROLLEE FOR ORIENTATION

If the CONTRACTOR Representative cannot contact the Enrollee within 10 working days or at all, the CONTRACTOR Representative will document its efforts to contact the Enrollee.

4. ENROLLEES RECEIVING OUT-OF-PLAN CARE PRIOR TO ORIENTATION

If the Enrollee receives Covered Services by an out-of-plan provider after the first day of the month in which the client's enrollment became effective, and if a CONTRACTOR orientation either in-person or by telephone (or in writing, but only if reasonable attempts have been made to make the contact in person or by telephone) has not taken place prior to receiving such services, the CONTRACTOR is responsible for payment of the services rendered provided the DEPARTMENT informs the CONTRACTOR by the 20th of any month prior to the month that MCO enrollment begins.

C. MARKETING AND MEMBER EDUCATION

1. APPROVAL OF MARKETING MATERIALS

The CONTRACTOR's marketing plans, procedures and materials will be accurate, and may not mislead, confuse, or defraud either Enrollees or the DEPARTMENT. All Medicaid marketing plans, procedures and materials will be reviewed and approved by the DEPARTMENT in consultation with the Medical Care Advisory Committee for Marketing Review before implemented or released by the CONTRACTOR. The DEPARTMENT will notify the CONTRACTOR of its approval or disapproval, in writing, of such materials within ten working days after receiving them unless the DEPARTMENT and the CONTRACTOR agree to another time frame. If the DEPARTMENT does not respond within the agreed upon time frame, the CONTRACTOR shall deem such materials approved. Marketing materials will not be approved if the DEPARTMENT determines that the material is materially inaccurate or misleading or otherwise makes material misrepresentations. Health education materials and newsletters not specifically related to Enrollees do not need to be approved by the DEPARTMENT.

a. NO DOOR-TO-DOOR, TELEPHONIC, OR "COLD CALL" MARKETING

The Contractor cannot, either directly or indirectly, conduct door-to-door, telephonic or "cold call" marketing of enrollment. These three marketing practices are prohibited whether conducted by the Health Plan itself ("directly") or by an agent or independent contractor ("indirectly"). Cold call marketing is any unsolicited personal contact with a potential enrollee by an employee or agent of a managed care entity for the purpose of influencing the individual to

enroll with the Health Plan. The Contractor may not entice a potential enrollee to join the Health Plan by offering the sale of any other type of insurance as a bonus for enrollment. All other non-requested marketing approaches to Medicaid clients by the CONTRACTOR are also prohibited unless specifically approved in advance by the DEPARTMENT.

b. DISTRIBUTION OF MARKETING MATERIALS

Marketing materials must be distributed to the entire Service Area.

2. ENROLLEE MATERIALS MUST BE COMPREHENSIBLE

The CONTRACTOR will attempt to write all Enrollee and potential enrollee information, instructional and educational materials, including member handbooks, at no greater than a sixth grade reading level. If the MCO has more than 5% of its Enrollees who speak a language other than English as a first language, the CONTRACTOR must make available written material (e.g. member handbooks, educational newsletters) in that language. Marketing materials must include a statement that the CONTRACTOR does not discriminate against any Enrollee on the basis of race, color, national origin, disability, or age in admission, treatment, or participation in its programs, services and activities. In addition, the materials must include the phone number of the nondiscrimination coordinator for Enrollees to call if they have questions about the nondiscrimination policy or desire to file a complaint or grievance alleging violations of the nondiscrimination policy.

3. MEMBER HANDBOOK

The CONTRACTOR will produce a member handbook that must be submitted to the DEPARTMENT for review and approval before distribution. The DEPARTMENT will notify the CONTRACTOR in writing of its approval or disapproval within ten working days after receiving the member handbook unless the DEPARTMENT and CONTRACTOR agree to another time frame. If the DEPARTMENT does not respond within the agreed upon time frame, the CONTRACTOR may deem such materials are approved. If there are changes to the content of the material in the handbook, the CONTRACTOR must update the member handbook and submit a draft to the DEPARTMENT for review and approval before distribution to its Enrollees. At a minimum, the member handbook must explain in clear terms the following information:

a. The scope of benefits provided by the MCO;
b. Instructions on where and how to obtain Covered Services, including referral requirements;
c. Instructions on what to do in an emergency or urgent medical situation, including emergency numbers;
d. Enrollee options on obtaining family planning services;
e. Instructions on how to choose a PCP and how to change PCPs;
f. Description on Enrollee cost-sharing requirements (if applicable);
g. Toll-free telephone number;
h. Description of Member Services function;

i. How to register a complaint or grievance;
j. Information on Advance Directives;
k. Services covered by Medicaid, but not covered by the CONTRACTOR;
l. Clients' rights and responsibilities;
m. A statement that the Contractor does not discriminate against any Enrollee on the basis of race, color, national origin, disability, or age in admission, treatment, or participation in its programs, services and activities; and
n. The phone number of the nondiscrimination coordinator for Enrollees to call if they have questions about the nondiscrimination policy or desire to file a complaint or grievance alleging violations of the nondiscrimination policy.

4. PLAN CARD

The CONTRACTOR must issue a generic plan card to all Enrollees listing, at a minimum, the name of the MCO and a toll-free number that is available to Enrollees twenty-four hours a day, seven days a week. The CONTRACTOR must issue the generic plan card to new enrollees within fifteen business days after the DEPARTMENT notifies the CONTRACTOR of the Medicaid client's enrollment.

5. NOTIFICATION TO ENROLLEES OF POLICIES AND PROCEDURES

a. CHANGES TO POLICIES AND PROCEDURES

The CONTRACTOR must periodically notify Enrollees, in writing, of changes to its plan such as changes to its policies or procedures either through a newsletter or other means.

b. ANNUAL EDUCATION ON EMERGENCY CARE AND GRIEVANCE PROCEDURES

The CONTRACTOR must annually reinforce, in writing, to Enrollees how to access emergency and urgent services and how to register a complaint or grievance.

6. MONTHLY NOTIFICATION TO DEPARTMENT OF CHANGES IN PROVIDER NETWORK

The CONTRACTOR must notify the DEPARTMENT at least monthly of changes in its provider network so that the DEPARTMENT can ensure its listing of providers is accurate.

D. DISENROLLMENT BY ENROLLEE

1. ENROLLEE'S RIGHT TO DISENROLL

Enrollees will have the right to disenroll from this MCO at any time with or without cause. The disenrollment will be effective once the DEPARTMENT has been notified by the Enrollee and the DEPARTMENT issues a new Medicaid card and the disenrollment is indicated on the Eligibility Transmission.

2. ENROLLEES IN AN INPATIENT HOSPITAL SETTING

The DEPARTMENT agrees that if a new Enrollee is a patient in an inpatient hospital setting on the date the new Enrollee's name appears on the CONTRACTOR Eligibility Transmission, the obligation of the CONTRACTOR to provide Covered Services to such person will commence following discharge. If an Enrollee is a patient in an inpatient hospital setting on the date that his or her name appears as a deleted Enrollee on the CONTRACTOR Eligibility Transmission or he or she is otherwise disenrolled under this Contract, the CONTRACTOR will remain financially responsible for such care until discharge.

3. ANNUAL STUDY OF ENROLLEES WHO DISENROLLED

Annually, the DEPARTMENT and CONTRACTOR will work cooperatively to conduct an analysis of Enrollees who have voluntarily disenrolled from this MCO. The results of the analysis will include explanations of patterns of disenrollments and strategies or a corrective action plan to address unusual rates or patterns of disenrollment. The DEPARTMENT will inform the CONTRACTOR of such disenrollments.

E. DISENROLLMENT BY CONTRACTOR

1. CANNOT DISENROLL FOR ADVERSE CHANGE IN ENROLLEE'S HEALTH

The CONTRACTOR may not terminate enrollment because of an adverse change in the Enrollee's health.

2. VALID REASONS FOR DISENROLLMENT

The CONTRACTOR may initiate disenrollment of any Enrollee's participation in the MCO upon one or more of the following grounds:

a. For reasons specifically identified in the CONTRACTOR's member handbook.
b. When the Enrollee ceases to be eligible for medical assistance under the State Plan, in accordance with Title 42 USCA, 1396, et. seq., and as finally determined by the DEPARTMENT.
c. Upon termination or expiration of the Contract.
d. Death of the Enrollee.
e. Confinement of the Enrollee in an institution when confinement is not a Covered Service under this Contract.
f. Violation of enrollment requirements developed by the CONTRACTOR and approved by the DEPARTMENT but only after the CONTRACTOR and/or the Enrollee has exhausted the CONTRACTOR's applicable internal grievance procedure.

3. APPROVAL BY DEPARTMENT REQUIRED

To initiate disenrollment of an Enrollee's participation with this MCO, the CONTRACTOR will provide the DEPARTMENT with documentation justifying the proposed disenrollment. The DEPARTMENT will approve or deny the disenrollment request in writing within thirty (30) days of receipt of the request. Failure by the DEPARTMENT to deny a disenrollment request within such thirty (30) day period will constitute approval of such disenrollment requests.

4. ENROLLEE'S RIGHT TO FILE A GRIEVANCE

If the DEPARTMENT approves the CONTRACTOR's disenrollment request, the CONTRACTOR will give the Enrollee thirty (30) days written notice of the proposed disenrollment, and will notify the Enrollee of his or her opportunity to invoke the internal grievance procedure and appeals process for a fair hearing. The CONTRACTOR will give a copy of the written notice to the DEPARTMENT at the time the notice is sent to the Enrollee.

5. REFUSAL OF RE-ENROLLMENT

If a person is disenrolled because of violation of responsibilities included in the CONTRACTOR's member handbook, the CONTRACTOR may refuse re-enrollment of that Enrollee.

F. ENROLLEE TRANSITION BETWEEN MCOS/HEALTH PLANS

1. MUST ACCEPT PRE-ENROLLMENT PRIOR AUTHORIZATIONS

For Covered Services other than inpatient, home health services, and medical equipment, if authorization has been given for a Covered Service and an enrollee transitions between MCOs prior to the delivery of such Covered Service, the receiving MCO shall be bound by the relinquishing MCO's prior authorization until the receiving MCO has evaluated the Enrollee and a new plan of care is established with the MCO provider. (See Article IV, Benefits, Section F, Clarification of Payment Responsibilities, Subsection 5, for inpatient, home health services, and medical equipment explanations.)

2. MUST PROVIDE MEDICAL RECORDS TO ENROLLEE'S NEW MCO

When enrollees are transitioned between MCOs the relinquishing MCO provider will submit, upon request of the new MCO provider, any critical medical information about the transitioning enrollee prior to the transition including, but not limited to, whether the member is hospitalized, pregnant, involved in the process of organ transplantation, scheduled for surgery or post-surgical follow-up on a date subsequent to transition, scheduled for prior-authorized procedures or therapies on a date subsequent to transition, receiving dialysis or is chronically ill (e.g. diabetic, hemophilic, HIV positive).

ARTICLE IV - BENEFITS

A. IN GENERAL

The CONTRACTOR will provide to Enrollees under this Contract, directly or through arrangements with subcontractors, all Medically Necessary Covered Services described in Attachment C as promptly and continuously as is consistent with generally accepted standards of medical practice. The CONTRACTOR provider will follow generally accepted standards of medical care in diagnosing Enrollees who request services from the CONTRACTOR.

B. PROVIDER SERVICES FUNCTION

The CONTRACTOR must operate a Provider Services function during regular business hours. At a minimum, Provider Services staff must be responsible for the following:

1. Training, including ongoing training, of network providers and subcontracting providers in Medicaid rules and regulations that will enable providers to appropriately provide services to Enrollees;

2. Assisting providers to verify whether an individual is enrolled with the MCO;

3. Assisting providers with prior authorization and referral protocols;

4. Assisting providers with claims payment procedures;

5. Fielding and responding to provider questions and complaints and grievances.

C. SCOPE OF SERVICES

1. UNDERWRITING RISK

In consideration of the premiums paid by the DEPARTMENT, the CONTRACTOR will, for all Enrollees, assume underwriting risk for Covered Services in Attachment C.

2. RESPONSIBLE FOR ALL BENEFITS IN ATTACHMENT C (COVERED SERVICES)

Except as otherwise provided for cases of Emergency Services, the CONTRACTOR has the exclusive right and responsibility to arrange for all benefits listed in Attachment C. The CONTRACTOR is responsible for payment of Emergency Services 24 hours a day and 7 days a week whether the service was provided by a network or out-of-network provider and whether the service was provided in or out of the CONTRACTOR's Service Area.

3. CHANGES TO BENEFITS

Amendments, revisions, or additions to the State Plan or to State or Federal regulations, guidelines, or policies and court or administrative orders will, insofar as they affect the scope or nature of benefits available to Enrollees, be amendments to the Covered

Services under Attachment C. The DEPARTMENT will notify the CONTRACTOR, in writing, of any such changes and their effective date. Rate adjustments, when appropriate, will be negotiated between the DEPARTMENT and the CONTRACTOR.

D. SUBCONTRACTS

1. NO DISCRIMINATION BASED ON LICENSE OR CERTIFICATION

The CONTRACTOR shall not discriminate against providers with respect to participation, reimbursement, or indemnification as to any provider who is 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.

2. ANY COVERED SERVICE MAY BE SUBCONTRACTED.

Any Covered Service may be subcontracted. All subcontracts will be in writing and will include the general requirements of this Contract that are appropriate to the service or activity including confidentiality requirements and will assure that all duties of the CONTRACTOR under this Contract are performed. No subcontract terminates the legal responsibility of the CONTRACTOR to the DEPARTMENT to assure that all activities under this Contract are carried out. The CONTRACTOR will make all subcontracts available upon request.

3. NO PROVISIONS TO REDUCE OR LIMIT MEDICALLY NECESSARY SERVICES

The CONTRACTOR will ensure that subcontractors abide by the requirements of Section 1128(b) of the Social Security Act prohibiting the CONTRACTOR and other such providers from making payments directly or indirectly to a physician or other provider as an inducement to reduce or limit Medically Necessary services provided to Enrollees.

4. REQUIREMENT OF 60 DAYS WRITTEN NOTICE PRIOR TO TERMINATION OF CONTRACT

All subcontracts and agreements will include a provision stating that if either party (the subcontractor or CONTRACTOR) wishes to terminate the subcontract or agreement, whichever party initiates the termination will give the other party written notice of termination at least 60 calendar days prior to the effective termination date. The CONTRACTOR will notify the DEPARTMENT of the termination on the same day that the CONTRACTOR either initiates termination or receives the notice of termination from the subcontractor.

5. COMPLIANCE WITH CONTRACTOR'S QUALITY ASSURANCE PLAN

All CONTRACTOR providers must be aware of the CONTRACTOR's Quality Assurance Plan and activities. All subcontracts with the CONTRACTOR must include a requirement securing cooperation with the CONTRACTOR's Quality Assurance Plan and activities and must allow the CONTRACTOR access to the subcontractor's medical records of its Enrollees.

6. UNIQUE IDENTIFIER REQUIRED

All physicians who provide services under this Contract must have a unique identifier in accordance with the system established under section 1173(b) of the Social Security Act and in accordance with the Health Insurance Portability and Accountability Act.

7. PAYMENT OF PROVIDER CLAIMS

The CONTRACTOR must pay its participating providers and subcontractors on a timely basis consistent with the claims payment procedures described in section 1902(a)(37)(A) of the Social Security Act and the implementing Federal regulation at 42 CFR 447.45, unless the health care provider and the Health Plan agree to an alternate payment schedule. The Contractor must ensure that 90 percent of claims for payment (for which no further written information or substantiation is required in order to make payment) made for Covered Services and furnished by subcontracting providers are paid within 30 days of receipt of such claims and that 99 percent of such claims are paid within 90 days of the date of receipt of such claims.

E. CLARIFICATION OF COVERED SERVICES

1. EMERGENCY SERVICES

a. IN GENERAL

The Health Plan must provide coverage for Emergency Services without regard to prior authorizations or the emergency care provider's contractual relationship with the MCO. MCOs must inform their enrollees that access to emergency services is not restricted and that if an enrollee experiences a medical emergency, he or she may obtain services from a non-plan physician or other qualified provider, without penalty. However, the MCO may require the enrollee to notify the MCO within a specified time after the Enrollee's condition is stabilized, and may require the enrollee to obtain prior authorization for any follow-up care delivered pursuant to the emergency. The CONTRACTOR must comply with Medicare guidelines for post-stabilization of care.

The CONTRACTOR must pay for services where the presenting symptoms are of sufficient severity that a person with average knowledge of health and medicine would reasonably expect the absence of immediate medical attention to result in (I) placing the health of the individual (or, with respect to a pregnant woman, the health of a woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

The CONTRACTOR may 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, turned out to be non-emergency in nature.

b. DETERMINING LIABILITY FOR EMERGENCY SERVICES

1) Presence of a clinical emergency

If the screening examination leads to a clinical determination by the examining physician that an actual emergency medical condition exists, the CONTRACTOR must pay for both the services involved in the screening examination and the services required to stabilize the Enrollee.

2) Emergency services continue until the Enrollee can be safely discharged or transferred

The CONTRACTOR must pay for all emergency services that 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 Enrollee's condition is likely to result from, or occur during, discharge of the Enrollee or transfer of the Enrollee to another facility. If there is a disagreement between a hospital and the CONTRACTOR concerning whether the Enrollee is stable enough for discharge or transfer, or whether the medical benefits of an unstabilized transfer outweigh the risks, the judgement of the attending physician(s) actually caring for the Enrollee at the treating facility prevails and is binding on the CONTRACTOR. The CONTRACTOR may establish arrangements with hospitals whereby the CONTRACTOR may send one of its own physicians with appropriate ER privileges to assume the attending physician's responsibilities to stabilize, treat, and transfer the Enrollee.

3) Absence of a clinical emergency

If the screening examination leads to a clinical determination by the examining physician that an actual emergency medical condition did not exist, then the determining factor for payment liability should be whether the Enrollee had acute symptoms of sufficient severity at the time of presentation. In these cases, the CONTRACTOR must review the presenting symptoms of the Enrollee and must pay for all services involved in the screening examination where the presenting symptoms (including severe pain) were of sufficient severity to have warranted emergency attention under the prudent layperson standard.

4) Referrals

When an Enrollee's Primary Care Physician or other plan representative instructs the Enrollee to seek emergency care in or out of network, the CONTRACTOR is responsible for payment of the medical screening examination and for other Medically Necessary emergency services, without regard to whether the Enrollee meets the prudent layperson standard.

c. CO-PAYMENTS

The CONTRACTOR may impose a co-payment of $[*] (or the amount Medicaid imposes on fee-for-service Medicaid clients) on Enrollees for non-emergency use of the emergency room and who are not exempt from being charged a co-payment. Those Enrollees who are exempt from liability for a co-payment are children under the age of 18 and women who are pregnant.

2. CARE PROVIDED IN SKILLED NURSING FACILITIES

a. IN GENERAL: STAYS LASTING 30 DAYS OR LESS

The CONTRACTOR may provide long term care for Enrollees in skilled nursing facilities and then reimburse such facilities when the plan of care includes a prognosis of recovery and discharge within 30 days. It is the responsibility of a CONTRACTOR physician to make the determination if the patient will require the services of a nursing facility for fewer or greater than 30 days.

b. PROCESS FOR STAYS LONGER THAN 30 DAYS

When the prognosis of an Enrollee indicates that long term care greater than 30 days will be required, the following process will occur:

1) The CONTRACTOR will notify the Enrollee, hospital discharge planner, and nursing facility that the CONTRACTOR will not be responsible for the services provided for the Enrollee during the stay at the skilled nursing facility.

2) The CONTRACTOR will notify the DHCF, Bureau of Managed Health Care, of this determination to suspend premium payment for that Enrollee.

3) If the CONTRACTOR incurs expenses, the Bureau of Managed Health Care will determine if the CONTRACTOR will retain the premium for the month during which the Enrollee is admitted to the skilled nursing facility. If the CONTRACTOR does not incur expenses during the month in which the Enrollee is admitted to a skilled nursing facility, the Bureau of Managed Health Care will retract from the CONTRACTOR the premium for that Enrollee.

4) Retraction of the premium payment will be subject to "3" above, but the Eligibility Transmission will indicate the non-payment on the first day of the month following the prognosis determination of greater than 30 days.

5) Premium payment to the CONTRACTOR will recommence beginning the first full month that the Enrollee is no longer residing in the nursing facility.

c. PROCESS FOR STAYS LESS THAN 30 DAYS

When the prognosis of skilled nursing facility services is anticipated to be less than 30 days, but during the 30-day period the CONTRACTOR determines that the Enrollee will require skilled nursing facility services for greater than 30 days, the following process will be in effect:

1) The CONTRACTOR will notify the nursing facility that a determination has been made that the Enrollee will require services for more than 30 days.

2) The CONTRACTOR will notify the DHCF, Bureau of Managed Health Care, of the determination that the Enrollee will require services in a nursing facility for more than 30 days.

3) If the CONTRACTOR incurs expenses for the Enrollee, the Bureau of Managed Health Care will determine if the CONTRACTOR will retain the premium for the month during which the change in status was determined. If the CONTRACTOR does not incur expenses during the month in which the change in status is determined, the Bureau of Managed Health Care will retract from the CONTRACTOR the premium for that Enrollee.

4) Retraction of the premium payment will be subject to "3" above, but the Recipient Subsystem will indicate the non-payment on the first day of the month following the prognosis determination of more than 30 days.

5) The CONTRACTOR will be responsible for payment for three working days after the CONTRACTOR has notified the nursing facility that skilled nursing care will be required for more than 30 days.

6) Premium payment to the CONTRACTOR will recommence beginning the first full month that the recipient is no longer residing in the nursing facility.

3. ENROLLEES WITH SPECIAL HEALTH CARE NEEDS

a. IN GENERAL

The CONTRACTOR will ensure there is access to all Medically Necessary Covered Services to meet the health needs of Enrollees with special health care needs. Individuals with special health care needs are those who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount beyond that required by adults and children generally. Such health conditions limit physical functioning, activities of daily living, or social role in comparison to age peers.

b. IDENTIFICATION

The CONTRACTOR will identify Enrollees with special health care needs using a process at the initial contact made by the CONTRACTOR Representative to educate the client and will offer the client care coordination or case management services. Care coordination services are services to assist the client in obtaining Medically Necessary Covered Services from the CONTRACTOR or another entity if the medical service is not covered under the Contract.

c. CHOOSING A PRIMARY CARE PROVIDER

The CONTRACTOR will have a mechanism to inform care givers and, when appropriate, Enrollees with special health care needs about primary care providers who have training in caring for such Enrollees so that an informed selection of a provider can be made. The CONTRACTOR will have primary care providers with skills and experience to meet the needs of Enrollees with special health care needs. The CONTRACTOR will allow an appropriate specialist to be the primary care provider but only if the specialist has the skills to monitor the Enrollee's preventive and primary care services.

d. REFERRALS AND ACCESS TO SPECIALTY PROVIDERS

The CONTRACTOR will ensure there is access to appropriate specialty providers to provide Medically Necessary Covered Services for adults and children with special health care needs. If the CONTRACTOR does not employ or contract with a specialty provider to treat a special health care condition at the time the Enrollee needs such Covered Services, the CONTRACTOR will have a process to allow the Enrollee to receive Covered Services from a qualified specialist who may not be affiliated with the CONTRACTOR. The CONTRACTOR will reimburse the specialist for such care at no less than Medicaid's rate for the service when the service is rendered. The process for requesting specialist's care will be clearly described by the CONTRACTOR and explained to each Enrollee during the initial contact with the Enrollee.

If the CONTRACTOR restricts the number of referrals to specialists, the CONTRACTOR will not penalize those providers who make such referrals for Enrollees with special health care needs.

e. SURVEY OF ENROLLEES WITH SPECIAL HEALTH CARE NEEDS

At least bi-annually, the CONTRACTOR, in conjunction with the DEPARTMENT, will survey a sample of Enrollees with special health care needs using a national consumer assessment questionnaire, to evaluate their perceptions of services they have received. The survey process, including the survey instrument, will be a standardized and developed collaboratively between the DEPARTMENT and all contracting MCOs. The DEPARTMENT will analyze the results of the surveys. The results and analysis of the surveys will be reviewed by the CONTRACTOR's quality assurance committee for action.

f. COLLABORATION WITH OTHER PROGRAMS

If the individual with special health care needs is enrolled in the Prepaid Mental Health Plan or is enrolled in any of the Medicaid home and community-based waiver programs and is receiving case management services through that program, or is covered by one of the other Medicaid targeted case management programs, the CONTRACTOR care coordinator will collaborate with the appropriate program person, i.e., the targeted case manager, etc., for that program once the program person has contacted the CONTRACTOR care coordinator. When necessary, the CONTRACTOR care coordinator will make an effort to contact the program person of those Enrollees who have medical needs that require such coordination.

g. REQUIRED ELEMENTS OF A CASE MANAGEMENT SYSTEM

A case management system includes but is not limited to:

1) procedures and the capacity to implement the provision of individual needs assessment including the screening for special needs (e.g. mental health, high risk health problems, functional problems, language or comprehension barriers); the development of an individual treatment plan as necessary based on the needs assessment; the establishment of treatment objectives, treatment follow-up, the monitoring of outcomes, and a process to ensure that treatment plans are revised as necessary. These procedures will be designed to accommodate the specific cultural and linguistic needs of the Enrollee;

2) procedures designed to address those Enrollees, including children with special health care needs, who may require services from multiple providers, facilities and agencies and require complex coordination of benefits and services, including social services and other community resources;

3) a strategy to ensure that all Enrollees and/or authorized Family Members or guardians are involved in treatment planning and consent to the medical treatment;

4) procedures and criteria for making referrals and coordinating care by specialists and sub-specialists that will promote continuity as well as cost-effectiveness of care; and

5) procedures to provide continuity of care for new Enrollees to prevent disruption in the provision of Covered Services that include, but are not limited to, appropriate case management staff able to evaluate and handle individual case transition and care planning, internal mechanisms to evaluate plan networks and special case needs.

h. HOSPICE

If an Enrollee is receiving hospice services at the time of enrollment in the MCO or if the Enrollee is already enrolled in the MCO and has less than six months to live, the Enrollee will be offered hospice services or the continuation of hospice services if he or she is already receiving such services prior to enrollment in the MCO.

4. INPATIENT HOSPITAL SERVICES

If a CONTRACTOR provider admits an Enrollee for inpatient hospital care, the CONTRACTOR has the responsibility for all services needed by the Enrollee during the hospital stay that are ordered by the CONTRACTOR provider. Needed services include but are not limited to diagnostic tests, pharmacy, and physician services, including services provided by psychiatrists. If diagnostic tests conducted during the inpatient stay reveal that the Enrollee's condition is outside the scope of the CONTRACTOR's responsibility, the CONTRACTOR remains responsible for the Enrollee until the Enrollee is discharged or until responsibility is transferred to another appropriate entity and the appropriate entity agrees to take financial responsibility, including negotiating a payment for services. If the Enrollee is discharged and needs further services, the admitting CONTRACTOR will coordinate with the other appropriate entity to ensure continued care is provided. The CONTRACTOR and appropriate entity will work cooperatively in the best interest of the Enrollee. The appropriate entity includes, but is not limited to, a Prepaid Mental Health Plan or another MCO.

5. MATERNITY STAYS

a. THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT (NMHPA)

The CONTRACTOR must meet the requirements of the Newborns' and Mothers' Health Protection Act (NMHPA). The CONTRACTOR must record early discharge information for monitoring, quality, and improvement purposes. The CONTRACTOR will ensure that coverage is provided with respect to a mother who is an Enrollee and her newborn child for a minimum of 48 hours of inpatient care following a normal vaginal delivery, and a minimum of 96 hours of inpatient care following a caesarean section, without requiring the attending provider to obtain authorization from the CONTRACTOR in order to keep a mother and her newborn child in the inpatient setting for such period of time.

b. EARLY DISCHARGES

Notwithstanding the prior sentence, the CONTRACTOR will not be required to provide coverage for post-delivery inpatient care for a mother who is an Enrollee and her newborn child during such period of time if (1) a decision to discharge the mother and her newborn child prior to the expiration of such period is made by the attending provider in consultation with the mother; and (2) the CONTRACTOR provides coverage for timely post-delivery follow-up care.

c. POST-DELIVERY CARE

Post-delivery care will be provided to a mother and her newborn child by a registered nurse, physician, nurse practitioner, nurse midwife or physician assistant experienced in maternal and child health in (1) the home, a provider's office, a hospital, a federally qualified health center, a federally qualified rural health clinic, or a State health department maternity clinic; or (2) another setting determined appropriate under regulations promulgated by the Secretary of Health and Human Services, (including a birthing center or an intermediate care facility); except that such coverage will ensure that the mother has the option to be provided with such care in the home.

d. TIMELY POST-DELIVERY CARE

"Timely post-delivery care" means health care that is provided (1) following the discharge of a mother and her newborn child from the inpatient setting; and (2) in a manner that meets the health needs of the mother and her newborn child, that provides for the appropriate monitoring of the conditions of the mother and child, and that occurs within the 24 to 72 hour period immediately following discharge.

6. CHILDREN IN CUSTODY OF THE DEPARTMENT OF HUMAN SERVICES

a. IN GENERAL

The CONTRACTOR will work with the Division of Child and Family Services (DCFS) or the Division of Youth Corrections (DYC) in the Department of Human Services (DHS) to ensure systems are in place to meet the health needs of children in custody of the Department of Human Services. The CONTRACTOR will ensure these children receive timely access to appointments through coordination with DCFS or DYC. The CONTRACTOR must have available providers who have experience and training in abuse and neglect issues.

The CONTRACTOR or subcontracting provider will make every reasonable effort to ensure that a child who is in custody of the Department of Human Services may continue to use the medical provider with whom the child has an established professional relationship when the medical provider is part of the CONTRACTOR's network. The CONTRACTOR will facilitate timely appointments with the provider of record to ensure continuity of care for the child.

While it is the CONTRACTOR's responsibility to ensure Enrollees who are children in custody of DHS have access to needed services, DHS personnel are primarily responsible to assist children in custody in arranging for and getting to medical appointments and evaluations with the CONTRACTOR's network of providers. DHS staff are primarily responsible for contacting the CONTRACTOR to coordinate care for children in custody and informing the

CONTRACTOR of the special health care needs of these Enrollees. The Fostering Healthy Children staff may assist the DHS staff in performing these functions by communicating with the CONTRACTOR.

b. SCHEDULE OF VISITS

1) Where physical and/or sexual abuse is suspected

In cases where the child protection worker suspects physical and/or sexual abuse the CONTRACTOR will ensure that the child has access to an appropriate examination within 24 hours of notification that the child was removed from the home. If the CONTRACTOR cannot provide an appropriate examination, the CONTRACTOR will ensure the child has access to a provider who can provide an appropriate examination within the 24 hour period.

2) All other cases

In all other cases, the CONTRACTOR will ensure that the child has access to an initial health screening within five calendar days of notification that the child was removed from the home. The CONTRACTOR will ensure this exam identifies any health problems that might determine the selection of a suitable placement, or require immediate attention.

3) CHEC exams

In all cases, the CONTRACTOR will ensure that the child has access to a Child Health Evaluation and Care (CHEC) screening within 30 calendar days of notification that the child was removed from the home. Whenever possible, the CHEC screening should be completed within the five-day time frame. Additionally, the CONTRACTOR will ensure the child has access to a CHEC screening according to the CHEC periodicity schedule until age six, then annually thereafter.

7. ORGAN TRANSPLANTATIONS

a. IN GENERAL

All organ transplantation services are the responsibility of the CONTRACTOR for all Enrollees in accordance with the criteria set forth in Rule R414-10A of the Utah Administrative Code, unless amended under the provisions of Attachment B, Article IV (Benefits), Section C, Subsection 3 of this Contract. The DEPARTMENT's criteria will be provided to the CONTRACTOR.

b. SPECIFIC ORGAN TRANSPLANTATIONS COVERED

The following transplantations are covered under Rule R414-10A: Kidney, liver, cornea, bone marrow, heart, intestine, lung, pancreas, small bowel, combination heart/lung, combination intestine/liver, combination kidney/pancreas, combination liver/kidney, multi visceral, and combination liver/small bowel.

c. PSYCHOSOCIAL ASSESSMENT REQUIRED

Medicaid requires that Medicaid eligibles who have applied for organ transplantations undergo a psychosocial assessment to assist in determining the Enrollees'/families' mental stability, commitment and potential to be compliant with the treatment and follow-up care that will go on for the rest of the Enrollee's life. This psychosocial evaluation is a Covered Service under this Contract.

If a request is made for a transplantation not listed above, the CONTRACTOR will contact the DEPARTMENT. Such requests will be addressed as set forth in R414-10A-23.

d. OUT-OF-STATE TRANSPLANTATIONS

When the CONTRACTOR arranges the transplantation to be performed out-of-state, the CONTRACTOR is responsible for coverage of food, lodging, transportation and airfare expenses for the Enrollee and attendant. The CONTRACTOR will follow, at a minimum, the DEPARTMENT's criteria for coverage of food, lodging, transportation and airfare expenses.

8. MENTAL HEALTH SERVICES

When an Enrollee presents with a possible mental health condition to his or her CONTRACTOR primary care physician, it is the responsibility of the primary care provider to determine whether the Enrollee should be referred to a psychologist, pediatric specialist, psychiatrist, neurologist, or other specialist. Mental health conditions may be handled by the CONTRACTOR primary care provider and referred to the Enrollee's Prepaid Mental Health Plan when more specialized services are required for the Enrollee. CONTRACTOR primary care providers may seek consultation from the Prepaid Mental Health Plan when the primary care provider chooses to manage the Enrollee's symptoms.

An independent panel comprised of specialists appropriate to the concern will be established by the DEPARTMENT with representative from the CONTRACTOR and Prepaid Mental Health Plan to adjudicate disputes regarding which entity (the CONTRACTOR or Prepaid Mental Health Plan) is responsible for payment and/or treatment of a condition. The panel will be convened on a case-by-case basis. The CONTRACTOR and Prepaid Mental Health Plan will adhere to the final decision of the panel.

9. DEVELOPMENTAL AND ORGANIC DISORDERS

a. COVERED SERVICES FOR CHILD ENROLLEES THROUGH AGE 20

1) The CONTRACTOR is responsible for all inpatient and physician outpatient Covered Services for child Enrollees with developmental (ICD-9 codes 299 through 299.8 and 317 through 319.9) or organic diagnoses (ICD-9 codes 290 through 294.9 and 310 through 310.9) including, but not limited to, diagnostic work-ups and other medical care such as medication management services related to the developmental or organic disorder.

2) The CONTRACTOR is responsible for all psychological evaluations and testing including neuropsychological evaluations and testing for child Enrollees with developmental or organic disorders such as brain tumors, brain injuries, and seizure disorders.

b. COVERED SERVICES FOR ADULT ENROLLEES AGE 21 AND OLDER

The CONTRACTOR is responsible for all inpatient and physician outpatient Covered Services for adult Enrollees with developmental (ICD-9 codes 299 through 299.8 and 317 through 319.9) and organic diagnoses (ICD-9 codes 290 through 294.9 and 310 through 310.9) including diagnostic work-ups and other medical care such as medication management services related to the developmental or organic disorder.

c. NON-COVERED SERVICES

1) Psychological evaluations and testing including neuropsychological evaluations and testing for adult Enrollees is not the responsibility of the CONTRACTOR.

2) Habilitative and behavioral management services are not the responsibility of the CONTRACTOR. If habilitative services are required, the Enrollee should be referred to the Division of Services for People with Disabilities (DSPD), the school system, the Early Intervention Program, or similar support program or agency. The enrollee should also be referred to DSPD for consideration of other benefits and programs that may be available through DSPD. Habilitative services are defined in Section 1915(c)(5)(a) of the Social Security Act as "services designed to assist individuals in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community based settings."

d. RESPONSIBILITY OF THE PREPAID MENTAL HEALTH PLAN

The Prepaid Mental Health Plan is responsible for needed mental health services to individuals with an organic and a psychiatric diagnosis or with a developmental and a psychiatric diagnosis..

10. OUT-OF-STATE ACCESSORY SERVICES

When the CONTRACTOR arranges a Covered Service to be performed out-of-state, the CONTRACTOR is responsible for coverage of airfare, food and lodging for the Enrollee and one attendant during the stay at the out-of-state facility and ground transportation costs to and from the medical facility at which the Enrollee is receiving services are also the responsibility of the CONTRACTOR. The CONTRACTOR will follow, at a minimum, the DEPARTMENT's criteria for coverage of food, lodging, transportation, and airfare expenses.

11. NON-CONTRACTOR PRIOR AUTHORIZATIONS

a. PRIOR AUTHORIZATIONS - GENERAL

The CONTRACTOR shall honor prior authorizations for organ transplantations and any other ongoing services initiated by the DEPARTMENT while the Enrollee was covered under Medicaid fee-for-service until the Enrollee is evaluated by the CONTRACTOR and a new plan of care is established.

b. WHEN THE CONTRACTOR HAS NOT AUTHORIZED THE SERVICE

For services that require a prior authorization, the CONTRACTOR will pay the provider of the service at the Medicaid rate, if the following conditions are met:

1) the servicing provider is not a participating provider under contract with the CONTRACTOR; and

2) the DEPARTMENT issued a prior authorization for an Enrollee to the servicing provider approving payment of the service; and

3) the servicing provider has completed the CONTRACTOR's hearing process without resolution of the claim, and has requested a hearing with the State Formal Hearings Unit requesting payment for the services rendered: and

4) in the hearing process it is determined that service rendered was a Medically Necessary service covered under this Contract, and that the CONTRACTOR will be responsible for payment of the claim.

The CONTRACTOR may elect to have payment of the servicing provider's claim made through the DEPARTMENT's MMIS system, with an equal reduction in the payments made to the CONTRACTOR

F. CLARIFICATION OF PAYMENT RESPONSIBILITIES

1. COVERED SERVICES RECEIVED OUTSIDE CONTRACTOR'S NETWORK BUT PAID BY CONTRACTOR

The CONTRACTOR will not be required to pay for Covered Services, defined in Attachment C, which the Enrollee receives from sources outside The CONTRACTOR's network, not arranged for and not authorized by the CONTRACTOR except as follows:

a. Emergency Services;

b. Court ordered services that are Covered Services defined in Attachment C and which have been coordinated with the CONTRACTOR; or

c. Cases where the Enrollee demonstrates that such services are Medically Necessary Covered Services and were unavailable from the CONTRACTOR.

2. WHEN COVERED SERVICES ARE NOT THE CONTRACTOR'S RESPONSIBILITY

a. The CONTRACTOR is not responsible for payment when family planning services are obtained by an Enrollee from sources other than the CONTRACTOR.

b. The CONTRACTOR will not be required to provide, arrange for, or pay for Covered Services to Enrollees whose illness or injury results directly from a catastrophic occurrence or disaster, including, but not limited to, earthquakes or acts of war. The effective date of excluding such Covered Services will be the date specified by the Federal Government or the State of Utah that a Federal or State emergency exists or disaster has occurred.

3. THE DEPARTMENT'S RESPONSIBILITY

Except as described in Attachment F (Rates and Rate-Related Terms) of this Contract, the DEPARTMENT will not be required to pay for any Covered Services under Attachment C which the Enrollee received from any sources outside the CONTRACTOR except for family planning services.

4. COVERED SERVICES PROVIDED BY THE DEPARTMENT OF HEALTH, DIVISION OF COMMUNITY AND FAMILY HEALTH SERVICES

For Enrollees who qualify for special services offered by or through the Department of Health, Division of Community and Family Health Services (DCFHS), the CONTRACTOR agrees to reimburse DCFHS at the standard Medicaid rate in effect at the time of service for one outpatient team evaluation and one follow-up visit for each Enrollee upon each instance that the Enrollee both becomes Medicaid eligible and selects the CONTRACTOR as its provider. The CONTRACTOR agrees to waive any prior authorization requirement for one outpatient team evaluation and one follow-up visit. The services provided in the outpatient team evaluation and follow-up visit for

which the CONTRACTOR will reimburse DCFHS are limited to the services that the CONTRACTOR is otherwise obligated to provide under this Contract.

If the CONTRACTOR desires a more detailed agreement for additional services to be provided by or through DCFHS for children with special health care needs, the CONTRACTOR may subcontract with DCFHS. The CONTRACTOR agrees that the subcontract with DCFHS will acknowledge and address the specific needs of DCFHS as a government provider.

5. ENROLLEE TRANSITION BETWEEN MCOS, OR BETWEEN FEE-FOR-SERVICE AND CONTRACTOR

a. INPATIENT HOSPITAL

When an Enrollee is in an inpatient hospital setting and selects another MCO or becomes fee-for-service anytime prior to discharge from the hospital, the CONTRACTOR is financially responsible for the entire hospital stay including all services related to the hospital stay, i.e. physician, etc. The MCO in which the individual is enrolled at the time of discharge from the hospital is financially responsible for services provided during the remainder of the month when the individual was discharged. If such individual is fee-for-service at the time of discharge from the hospital, the DEPARTMENT is financially responsible for the remainder of the month when the individual was discharged. If a Medicaid eligible is in an inpatient hospital setting and selects the MCO anytime prior to discharge from the hospital, the DEPARTMENT is financially responsible for the entire hospital stay including all services related to the hospital stay, i.e. physician, etc. Enrollees who are in an inpatient hospital setting at the time the CONTRACTOR terminates this Contract and who have enrolled with another MCO are the responsibility of the receiving MCO beginning the day after the termination is effective.

b. HOME HEALTH SERVICES

Medicaid clients who are under fee-for-service or are enrolled in an MCO other than this MCO and are receiving home health services from an agency not contracting with the CONTRACTOR will be transitioned to the CONTRACTOR's home health agency. The CONTRACTOR is responsible for payment, not to exceed Medicaid payment, for a period not to exceed seven calendar days, unless the CONTRACTOR and the home health agency agree to another time period in writing, after the CONTRACTOR notifies the non-participating home health agency of the change in status or the non-participating home health agency notifies the CONTRACTOR that services are being provided by its agency. The CONTRACTOR will assess the needs of the Enrollee at the time the CONTRACTOR provides the orientation to the Enrollee.

The CONTRACTOR will include the Enrollee in developing the plan of care to be provided by the CONTRACTOR's home health agency before the transition is complete. The CONTRACTOR will address Enrollee's concerns regarding

Covered Services provided by the CONTRACTOR's home health agency before the new plan of care is implemented.

c. MEDICAL EQUIPMENT

When medical equipment is ordered for an Enrollee by the CONTRACTOR and the Enrollee enrolls in a different MCO before receiving the equipment, the CONTRACTOR is responsible for payment for such equipment. Medical equipment includes specialized wheelchairs or attachments, prosthesis, and other equipment designed or modified for an individual client. Any attachments to the equipment, replacements, or new equipment is the responsibility of the MCO in which the client is enrolled at the time such equipment is ordered.

6. SURVEYS

All surveys required under this Contract will be funded by the CONTRACTOR unless funded by another source such as the Utah Department of Health Office of Health Data Analysis. The surveys must be conducted by an independent vendor mutually agreed upon by the DEPARTMENT and CONTRACTOR. The DEPARTMENT or designee will analyze the results of the surveys. Before publishing articles, data, reports, etc. related to surveys the DEPARTMENT will provide drafts of such material to the CONTRACTOR for review and feedback. The CONTRACTOR will not be responsible for the costs incurred for such publishing by the DEPARTMENT.

ARTICLE V - ENROLLEE RIGHTS/SERVICES

A. MEMBER SERVICES FUNCTION

The CONTRACTOR must operate a Member Services function during regular business hours. Ongoing training, as necessary, shall be provided by the CONTRACTOR to ensure that the Member Services staff is conversant in the CONTRACTOR's policies and procedures as they relate to Enrollees. At a minimum, Member Services staff must be responsible for the following:

1. Explaining the CONTRACTOR's rules for obtaining services;

2. Assisting Enrollees to select or change primary care providers;

3. Fielding and responding to Enrollee questions and complaints and grievances.

The CONTRACTOR shall conduct ongoing assessment of its orientation staff to determine staff member's understanding of the MCO and its Medicaid managed care policies and provide training, as needed.

B. ENROLLEE LIABILITY

1. The CONTRACTOR will not hold an Enrollee liable for the following:

   a. The debts of the CONTRACTOR if it should become insolvent.

   b. Payment for services provided by the CONTRACTOR if the CONTRACTOR has not received payment from the DEPARTMENT for the services, or if the provider, under contract with the CONTRACTOR, fails to receive payment from the CONTRACTOR.

   c. The payments to providers that furnish Covered Services under a contract or other arrangement with the CONTRACTOR that are in excess of the amount that normally would be paid by the Enrollee if the service had been received directly from the CONTRACTOR.

C. GENERAL INFORMATION TO BE PROVIDED TO ENROLLEES

The CONTRACTOR will make the following information available to Enrollees and potential enrollees on request:

1. The identity, locations, qualification, and availability of participating providers (at a minimum, area of specialty, board certification, and any special areas of expertise must be available that would be helpful to individuals deciding whether to enroll with the CONTRACTOR);

2. The rights and responsibilities of Enrollees;

3. The procedures available to Enrollees and providers to challenge or appeal the failure of the CONTRACTOR to cover a services; and

4. All items and services that are available to Enrollees that are covered either directly or through a method of referral or prior authorization.

D. ACCESS

1. IN GENERAL

   The CONTRACTOR shall provide the DEPARTMENT and the Health Care Financing Administration, adequate assurances that the CONTRACTOR, with respect to a service area, has the capacity to serve the expected enrollment in such service area, including assurances that the CONTRACTOR offers an appropriate range of services and access to preventive and primary care services for the population expected to enroll in such service area, and maintains a sufficient number, mix and geographic distribution of providers of services.

   The CONTRACTOR will provide services which are accessible to Enrollees and appropriate in terms of timeliness, amount, duration, and scope.

2. SPECIFIC PROVISIONS

a. ELIMINATION OF ACCESS PROBLEMS CAUSED BY GEOGRAPHIC, CULTURAL AND LANGUAGE BARRIERS AND PHYSICAL DISABILITIES

The CONTRACTOR will minimize, with a goal to eliminate, Enrollee's access problems due to geographic, cultural and language barriers, and physical disabilities. The CONTRACTOR will provide assistance to Enrollees who have communication impediments or impairments to facilitate proper diagnosis and treatment. The CONTRACTOR must guarantee equal access to services and benefits for all Enrollees by making available interpreters, Telecommunication Devices for the Deaf (TDD), and other auxiliary aids to all Enrollees as needed. The CONTRACTOR will accommodate Enrollees with physical and other disabilities in accordance with the American Disabilities Act of 1990 (ADA), as amended. If the CONTRACTOR's facilities are not accessible to Enrollees with physical disabilities, the CONTRACTOR will provide services in other accessible locations.

b. INTERPRETIVE SERVICES

The CONTRACTOR will provide interpretive services for languages on an as needed basis. These requirements will extend to both in-person and telephone communications to ensure that Enrollees are able to communicate with the CONTRACTOR and CONTRACTOR providers and receive Covered Services. Professional interpreters will be used when needed where technical, medical, or treatment information is to be discussed, or where use of a Family Member or friend as interpreter is inappropriate. A family member or friend may be used as an interpreter if this method is requested by the patient, and the use of such a person would not compromise the effectiveness of services or violate the patient's confidentiality, and the patient is advised that a free interpreter is available.

c. NO RESTRICTIONS OF PROVIDER'S ABILITY TO ADVISE AND COUNSEL

The CONTRACTOR may not restrict a health care provider's ability to advise and counsel Enrollees about Medically Necessary treatment options. All contracting providers acting within his or her scope of practice, must be permitted to freely advise an Enrollee about his or her health status and discuss appropriate medical care or treatment for that condition or disease regardless of whether the care or treatment is a Covered Service.

d. WAITING TIME BENCHMARKS

The CONTRACTOR will adopt benchmarks for waiting times for physician appointments as follows:

Waiting Time for Appointments

1) Primary Care Providers:
   - within 30 days for routine, non-urgent appointments
   - within 60 days for school physicals
   - within 2 days for urgent, symptomatic, but not life-threatening care (care that can be treated in the doctor's office)

2) Specialists:
   - within 30 days for non-urgent
   - within 2 days for urgent, symptomatic, but not life-threatening care (care that can be treated in a doctor's office)

These benchmarks do not apply to appointments for regularly scheduled visits to monitor a chronic medical condition if the schedule calls for visits less frequently than once every month.

e. NO DELAY WHILE COORDINATING COVERAGE WITH A PREPAID MENTAL HEALTH PLAN

When an Enrollee is also enrolled in a Prepaid Mental Health Plan, the CONTRACTOR will not delay an Enrollee's access to needed services in disputes regarding responsibility for payment. Payment issues should be addressed only after needed services are rendered. As described in Attachment B, IV (Benefits), Section E (Clarification of Covered Services), Subsection 8 of this Contract, the independent panel established by the DEPARTMENT will assist in adjudicating such disputes when requested to do so by either party.

E. CHOICE

The CONTRACTOR must allow Enrollees the opportunity to select a participating Primary Care Provider. This excludes clients who are under the Restriction Program. If an Enrollee's Primary Care Provider ceases to participate in the CONTRACTOR's network, the CONTRACTOR must offer the Enrollee the opportunity to select a new Primary Care Provider.

F. COORDINATION

1. IN GENERAL

The CONTRACTOR will provide access to a coordinated, comprehensive and continuous array of needed services through coordination with other appropriate entities. The CONTRACTOR provider is not responsible for directly providing waiver services.

2. PREPAID MENTAL HEALTH PLAN

a. When an Enrollee is also enrolled in a Prepaid Mental Health Plan, the CONTRACTOR and Prepaid Mental Health Plan will share appropriate information regarding the Enrollee's health care to ensure coordination of physical and mental health care services.

b. Clients enrolled in the MCO and a Prepaid Mental Health Plan who due to a psychiatric condition require lab, radiology and similar outpatient services covered under this Contract, but prescribed by the Prepaid Mental Health Plan physician, will have access to such services in a timely fashion. The CONTRACTOR and Prepaid Mental Health Plan will reduce or eliminate unnecessary barriers that may delay the Enrollee's access to these critical services.

G. BILLING ENROLLEES

1. IN GENERAL

Except as provided herein Attachment B, Article V (Enrollee Rights/Services), Section G (Billing Enrollees), no claim for payment will be made at any time by the CONTRACTOR or CONTRACTOR provider to an Enrollee accepted by that provider as a Medicaid Enrollee for any service covered under this Contract. When a provider accepts an Enrollee as a patient he or she will look solely to third party coverage or the CONTRACTOR for reimbursement. If the provider fails to receive payment from the CONTRACTOR, the Enrollee cannot be held responsible for these payments.

2. CIRCUMSTANCES WHEN AN ENROLLEE MAY BE BILLED

An Enrollee may in certain circumstances be billed by the CONTRACTOR provider for non-Covered Services. A non-Covered Service is one that is not covered under this Contract, or includes special features or characteristics that are desired by the Enrollee, such as more expensive eyeglass frames, hearing aids, custom wheelchairs, etc., but do not meet the Medical Necessity criteria for amount, duration, and scope as set forth in the Utah State Plan. The DEPARTMENT will specify to the CONTRACTOR the extent of Covered Services and items under the Contract, as well as services not covered under the Contract but provided by Medicaid on a fee-for-service basis that would effect the CONTRACTOR's Covered Services. An Enrollee may be billed for a service not covered under this Contract only when the following conditions are met:

a. The CONTRACTOR has an established policy for billing all patients for services not covered by a third party. (Non-Covered Services cannot be billed only to Enrollees.)

b. The CONTRACTOR will inform Enrollees of its policy and the services and items that are non covered under this Contract and include this information in the Enrollee's member handbook.

c. The CONTRACTOR provider will advise the Enrollee prior to rendering the service that the service is not covered under this Contract and that the Enrollee will be personally responsible for making payment.

d. The Enrollee agrees to be personally responsible for the payment and an agreement is made in writing between the CONTRACTOR provider and the Enrollee which details the service and the amount to be paid by the Enrollee.

3. CONTRACTOR MAY NOT HOLD ENROLLEE'S MEDICAID CARD

The CONTRACTOR or CONTRACTOR provider will not hold the Enrollee's Medicaid card as guarantee of payment by the Enrollee, nor may any other restrictions be placed upon the Enrollee.

4. CRIMINAL PENALTIES

Criminal penalties shall be imposed on MCO providers as authorized under section 1128B(d)(l)of the Social Security Act if the provider knowingly and willfully charges an Enrollee at a rate other than those allowed under this Contract.

ARTICLE VI - GRIEVANCE PROCEDURES

A. IN GENERAL

The CONTRACTOR will maintain a system for reviewing and adjudicating complaints and grievances by Enrollees, and providers. The CONTRACTOR's complaint and grievance procedures must permit an Enrollee, or provider on behalf of an Enrollee, to challenge the denials of coverage of medical assistance or denials of payment for Covered Services. The CONTRACTOR will submit such grievance plans and procedures to the DEPARTMENT for approval prior to instituting or changing such procedures. Such procedures will provide for expeditious resolution of complaints and grievances by the CONTRACTOR's personnel who have authority to correct problems.

B. NONDISCRIMINATION

The Contractor shall designate a nondiscrimination coordinator who will 1) ensure the Contractor complies with Federal Laws and Regulations regarding nondiscrimination, and 2) take complaints and grievances from Enrollees alleging nondiscrimination violations based on race, color, national origin, disability, or age. The nondiscrimination coordinator may also handle complaints regarding the violation of other civil rights (sex and religion) as other Federal laws and Regulations protect against these forms of discrimination. The Contractor will develop and implement a written method of administration to assure that the Contractor's programs, activities, services, and benefits are equally available to all persons without regard to race, color, national origin, disability, or age.

C. MINIMUM REQUIREMENTS OF GRIEVANCE PROCEDURES

1. Definitions of complaints and grievance;
2. Details of how, when, where and with whom an Enrollee or provider may file a grievance;
3. Assurances of the participation of individuals with authority to take corrective action;
4. Responsibilities of the various components and staff of the organization;
5. Description of the process for timely review, prompt (45 days) resolution of complaints and grievances;
6. Details of an appeal process; and

7. Provision stating that during the pendency of any grievance procedure or an appeal of such grievances, the Enrollee will remain enrolled except as otherwise stated in this Contract.

D. FINAL REVIEW BY DEPARTMENT

When an Enrollee or provider has exhausted the CONTRACTOR's grievance process and a final decision has been made, the CONTRACTOR must provide written notification to the party who initiated the grievance of the grievance's outcome and explain in clear terms a detailed reason for the denial.

The CONTRACTOR must provide notification to Enrollees and providers that the final decision of the CONTRACTOR may be appealed to the DEPARTMENT and will give to the Enrollee or provider the DEPARTMENT's form to request a formal hearing with the DEPARTMENT. The MCO must inform the Enrollee or provider the time frame for filing an appeal with the DEPARTMENT. The formal hearing with the DEPARTMENT is a de novo hearing. If the Enrollee or provider request a formal hearing with the DEPARTMENT, all parties to the formal hearing agree to be bound by the DEPARTMENT's decision until any judicial reviews are completed and are in the Enrollee's or provider's favor. Any decision made by the DEPARTMENT pursuant to the hearing shall be subject to appeal rights as provided by State and Federal laws and rules.

ARTICLE VII - OTHER REQUIREMENTS

A. COMPLIANCE WITH PUBLIC HEALTH SERVICE ACT

The CONTRACTOR will comply with all requirements of Section 1301 to and including 1318 of the Public Health Service Act. The CONTRACTOR will provide verification of such compliance to the DEPARTMENT upon the DEPARTMENT's request. This Contract is a "prospective risk" contract which means that payment is made by means of a capitation rate offered each month as reimbursement in advance for services incurred that month regardless of the level of utilization actually experienced. Nothing herein will be construed or interpreted to mean that this is a cost reimbursement contract. Cost reimbursement means payment is made by means of a settlement based on cost incurred over a given period.

B. COMPLIANCE WITH OBRA'90 PROVISION AND 42 CFR 434.28

The CONTRACTOR will comply with the OBRA '90 provision which requires an MCO provide patients with information regarding their rights under State law to make decisions about their health care including the right to execute a living will or to grant power of attorney to another individual.

The CONTRACTOR will comply with the requirements of 42 CFR 434.28 relating to maintaining written Advance Directives as outlined under Subpart I of 489.100 through 489.102.

C. FRAUD AND ABUSE REQUIREMENTS

The CONTRACTOR agrees to abide by Federal and/or State fraud and abuse requirements including, but not limited to, the following:

1. Refer in writing to the DEPARTMENT all detected incidents of potential fraud or abuse on the part of providers of services to Enrollees or to other patients.

2. Refer in writing to the DEPARTMENT all detected incidents of patient fraud or abuse involving Covered Services provided which are paid for in whole, or in part, by the DEPARTMENT.

3. Refer in writing to the DEPARTMENT the names and Medicaid ID numbers of those Enrollees that the CONTRACTOR suspects of inappropriate utilization of services, and the nature of the suspected inappropriate utilization.

4. Inform the DEPARTMENT in writing when a provider is removed from the CONTRACTOR's panel for reasons relating to suspected fraud, abuse or quality of care concerns.

5. The CONTRACTOR may not employ or subcontract with any sanctioned provider. The DEPARTMENT will inform the CONTRACTOR of any provider sanctioned by Medicaid or Medicare.

   The CONTRACTOR may not employ or subcontract with any provider who is an ineligible entity as defined under the State Medicaid Manual Section 2086.16. This section is available upon request. The CONTRACTOR will attest that the entities listed below are not involved with the CONTRACTOR. Ineligible organizations can be included in the following categories as referenced in the Social Security Act (the Act):

   a. Entities which could be excluded under section 1128(b)(8) of the Act--these are entities in which a person who is an officer, director, agent, or managing employee of the entity, or a person who has a direct or indirect ownership or control interest of 5% or more in the entity and has been convicted of the following crimes:

      1) any criminal offense related to the delivery of a Medicare or Medicaid item or service (see section 1128(a)(l) of the Act);

      2) patient abuse (section 1128(a)(2));

      3) fraud (1128(b)(l));

      4) obstruction of an investigation (1128(b)(2)); or

      5) offenses related to controlled substances (1128(b)(3)).

b. Entities which have a direct or indirect substantial contractual relationship with an individual or entity listed in subsection "a" above-- a substantial contractual relationship is defined as any contractual relationship which provides for one or more of the following:

   1) the administration, management, or provision of medical services;

   2) the establishment of policies pertaining to the administration, management or provision of medical services; or

   3) the provision of operational support for the administration, management, or provision of medical services.

c. Entities which employ, contract with, or contract through any individual or entity that is excluded from participation in Medicaid under Section 1128 or 1128A of the Act, for the provision of health care, utilization review, medical social work or administration services.

D. DISCLOSURE OF OWNERSHIP AND CONTROL INFORMATION

The CONTRACTOR agrees to meet the requirements of 42 CFR 455, Subpart B related to disclosure by the CONTRACTOR of ownership and control information.

E. SAFEGUARDING CONFIDENTIAL INFORMATION ON ENROLLEES

The CONTRACTOR agrees that information about Enrollees is confidential information and agrees to safeguard all confidential information and conform to the requirements set forth in 42CFR, Part 431, Subpart F as well as all other applicable Federal and State confidentiality requirements.

F. DISCLOSURE OF PROVIDER INCENTIVE PLANS

Per 42 CFR 417.749(a), no specific payment can 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 Enrollee.

The CONTRACTOR may operate a physician incentive plan only if the stop-loss protection, Enrollee survey, and disclosure requirements are met. The CONTRACTOR must disclose to the DEPARTMENT the following information on provider incentive plans in sufficient detail to determine whether the incentive plan complies with the regulatory requirements. The disclosure must contain:

1. Whether services not furnished by the physician or physician group are covered by the incentive plan. If only the services furnished by the physician or physician group are covered by the incentive plan, disclosure of other aspects of the plan need not be made.

2. The type of incentive arrangement (i.e., withhold, bonus, capitation).

3. If the incentive plan involves a withhold or bonus, the percent of the withhold or bonus.

4. Proof that the physician or physician group has adequate stop-loss protection, including the amount and type of stop-loss protection.

5. The panel size and, if patients are pooled; the method used.

6. To the extent provided for in HCFA implementation guidelines, capitation payments paid to primary care physicians for the most recent year broken down by percent for primary care services, referral services to specialists, and hospital and other types of provider services (i.e., nursing home and home health agency) for capitated physicians or physician groups.

7. In the case of those prepaid plans that are required to conduct beneficiary surveys, the survey results. (The Contractor must conduct a customer satisfaction of both Enrollees and disenrollees if any physicians or physicians groups contracting with the CONTRACTOR are placed at substantial financial risk for referral services. The survey must include either all current Enrollees and those who have disenrolled in the past twelve months, or a sample of these same Enrollees and disenrollees. Recognizing that different questions are asked of the disenrollees than those asked of Enrollees, the same survey cannot be used for both populations.)

The CONTRACTOR must disclose this information to the DEPARTMENT (1) prior to approval of its contract or agreement and (2) upon the contract or agreements anniversary or renewal effective date. The CONTRACTOR must provide the capitation data required (see 6 above) for the previous contract year to the DEPARTMENT three months after the end of the contract year. The CONTRACTOR will provide to the Enrollee upon request whether the CONTRACTOR uses a physician incentive plan that affects the use of referral services, the type of incentive arrangement, whether stop-loss protection is provided, and the survey results of any enrollee/disenrollee surveys conducted.

G. DEBARRED OR SUSPENDED INDIVIDUALS

Under Section 1921(d)(1) of the Social Security Act, the CONTRACTOR may not knowingly have a director, officer, partner, or person with beneficial ownership of more than 5% of the CONTRACTOR's equity who has been debarred or suspended by any federal agency. The CONTRACTOR may not have an employment, consulting, or any other agreement with a debarred or suspended person for the provision of items or services that are significant and material to meeting the provisions under this Contract.

The CONTRACTOR must certify to the DEPARTMENT that the requirements under Section 1921(d)(l) of the Social Security Act are met prior to the effective date of this Contract and at any time there is a change from the last such certification.

H. HCFA CONSENT REQUIRED

If HCFA directs the DEPARTMENT to terminate this Contract, the DEPARTMENT will not be permitted to renew this Contract without HCFA consent.

ARTICLE VIII - PAYMENTS

A. RISK CONTRACT

This Contract is a risk contract as described in 42 CFR 447.361. Payments made to the CONTRACTOR may not exceed the cost to the DEPARTMENT of providing these same Covered Services on a fee-for-service basis, to an actuarially equivalent non-enrolled population.

B. PAYMENT AMOUNTS

1. PAYMENT SCHEDULE

On or before the 10th day of each month, the DEPARTMENT will pay to the CONTRACTOR the premiums due for each category shown for Enrollees for that month as determined by the DEPARTMENT from the Eligibility Transmission. Premiums shown in Attachment F-3 are based on rate negotiations between the CONTRACTOR and the DEPARTMENT.

2. CALCULATION OF PREMIUMS

The premiums do not include payment for recoupment of any previous losses incurred by the CONTRACTOR. The premiums established in this Contract will be prospectively set so as not to exceed the cost of providing the same Covered Services to an actuarially equivalent non-enrolled Medicaid population. The actuarially set fee-for-service equivalents developed by the DEPARTMENT are prospectively determined and conform with Federal guidelines as defined in CFR 447.361.

3. FEDERALLY QUALIFIED HEALTH CENTERS (FQHCS)

If the CONTRACTOR enters into a subcontract with a Federally Qualified Health Center (FQHC), the CONTRACTOR will reimburse the FQHC an amount equal to what the CONTRACTOR pays comparable providers that are not FQHCs. The FQHC may be entitled to additional reimbursement from the DEPARTMENT for the difference between CONTRACTOR payments to the FQHC and the FQHC's reasonable costs. The cost audits will be conducted by the DEPARTMENT. If the CONTRACTOR has a capitated arrangement with an FQHC, the DEPARTMENT is not responsible to either the CONTRACTOR or the FQHC for 100% of the FQHC's reasonable costs.

4. TIME FRAME FOR REQUEST OF DELIVERY PAYMENT

The CONTRACTOR will submit a request for payment of the lump sum delivery amount within six months of the delivery date.

5. CONTRACT MAXIMUM

In no event will the aggregate amount of payments to the Contractor exceed the Contract maximum amount. If payments to the CONTRACTOR approach or exceed the Contract amount before the renewal date of the Contract, the DEPARTMENT shall execute a

Contract amendment to increase the Contract amount within 30 calendar days of the date the Contract amount is exceeded.

C. MEDICARE

1. PAYMENT OF MEDICARE PART B PREMIUMS

The DEPARTMENT will pay the Medicare Part B premium for each Enrollee who is on Medicare. The Enrollee will assign to the CONTRACTOR his or her Medicare reimbursement for benefits received under Medicare. The Eligibility Transmission includes and identifies those Enrollees who are covered under Medicare.

2. PAYMENT OF MEDICARE DEDUCTIBLE AND COINSURANCE

The DEPARTMENT's financial obligation under this Contract for Enrollees who are covered by both Medicare and the MCO is limited to the Medicare Part B premium and the CONTRACTOR premium. The CONTRACTOR is responsible for payment of the Medicare deductible and coinsurance for Enrollees when a service is paid for by Medicare. The CONTRACTOR is responsible for payment whether or not the Medicare covered service is rendered by a CONTRACTOR provider or has been authorized by the CONTRACTOR. If a Medicare covered service is rendered by an out-of-plan Medicare provider or a non-Medicare participating provider, the CONTRACTOR is responsible to pay for no more than the Medicare authorized amount. Attachment E, Table 2, will be used to identify the total cost to the CONTRACTOR of providing care for Enrollees who are also covered by Medicare.

3. MUST NOT BALANCE BILL ENROLLEES

The CONTRACTOR and CONTRACTOR provider will not Balance Bill the Enrollee and will consider the reimbursement from Medicare and from the CONTRACTOR payment in full.

D. THIRD PARTY LIABILITY (COORDINATION OF BENEFITS)

The DEPARTMENT will provide the CONTRACTOR a monthly listing of Enrollees covered under the Buy-out Program, including the premium amount paid by the DEPARTMENT.

1. TPL COLLECTIONS

The CONTRACTOR will be responsible to coordinate benefits and collect third party liability (TPL). The CONTRACTOR will keep TPL collections. The DEPARTMENT will set rates net of expected TPL collections excluding the lump sum rate set for deliveries. The rate set for deliveries is the maximum amount the DEPARTMENT will pay the CONTRACTOR for each delivery. The CONTRACTOR must attempt to collect TPL before the DEPARTMENT will reimburse the CONTRACTOR the delivery rate less TPL. The DHCF audit staff will monitor collections to ensure the CONTRACTOR is making a good faith effort to pursue TPL. The DEPARTMENT will properly account for TPL in its rate structure.

The CONTRACTOR will provide a quarterly match of Enrollees to the CONTRACTOR's commercial insurance eligibility files. The Office of Recovery Services (ORS) will provide an electronic list of

2. DUPLICATION OF BENEFITS

This provision applies when, under another health insurance plan such as a prepaid plan, insurance contract, mutual benefit association or employer's self-funded group health and welfare program, etc., an Enrollee is entitled to any benefits that would totally or partially duplicate the benefits that the CONTRACTOR is obligated to provide under this Contract. Duplication exists when (1) the CONTRACTOR has a duty to provide, arrange for or pay for the cost of Covered Services, and (2) another health insurance plan, pursuant to its own terms, has a duty to provide, arrange for or pay for the same type of Covered Services regardless of whether the duty of the CONTRACTOR is to provide the Covered Services and the duty of the other health insurance plan is only to pay for the Covered Services. Under State and Federal laws and regulations, Medicaid funds are the last dollar source and all other health insurance plans as referred to above are primarily responsible for the costs of providing Covered Services.

3. RECONCILIATION OF OTHER TPL

In order to assist the CONTRACTOR in billing and collecting from other health insurance plans the DEPARTMENT will include on the Eligibility Transmission other health insurance plans of each Enrollee when it is known. The CONTRACTOR will review the Eligibility Transmission and will report to the Office of Recovery Services or the DEPARTMENT any TPL discrepancies identified within 30 working days of receipt of the Eligibility Transmission. The CONTRACTOR's report will include a listing of Enrollees that the CONTRACTOR has independently identified as being covered by another health insurance plan.

4. WHEN TPL IS DENIED

On a monthly basis, the CONTRACTOR will report to the Office of Recovery Services (ORS) claims that have been billed to other health care plans but have been denied which will include the following information:

a. patient name and Medicaid identification number
b. ICD-9-CM code;
c. procedure codes; and
d. insurance company.

5. NOTIFICATION OF PERSONAL INJURY CASES

The CONTRACTOR will be responsible to notify ORS of all personal injury cases, as defined by ORS and agreed to by the CONTRACTOR, no later than 30 days after the CONTRACTOR has received a "clean" claim. A clean claim is a claim that is ready to adjudicate. The following data elements will be provided by the CONTRACTOR to ORS:

a. patient name and Medicaid identification number
b. date of accident;
c. specific type of injury by ICD-9-CM code;
d. procedure codes; and
e. insurance company, if known.

6. ORS TO PURSUE COLLECTIONS

ORS will pursue collection on all claims described in Attachment B, Article VIII (Payments), Section D, Subsections 4 and 5 of this Contract. The DEPARTMENT will retain, for administrative costs, one third of the collections received for the period during which medical services were provided by the CONTRACTOR, and remit the balance to the CONTRACTOR.

7. REBATE OF DUPLICATE PREMIUMS

The CONTRACTOR will rebate to the DEPARTMENT on a quarterly basis any duplicate premiums paid to the CONTRACTOR for Enrollees. Payments are deemed duplicate when the CONTRACTOR receives premium both from the DEPARTMENT and from another payment source for the same Enrollee or from the DEPARTMENT and from the Medicaid Buy-out Program for the same Enrollee.

8. INSURANCE BUY-OUT PROGRAM

The Insurance Buy-out Program is an optional program in which the DEPARTMENT purchases group health insurance for a recipient who is eligible for Medicaid when it is determined cost-effective for the Medicaid program to do so. The insurance buy-out process will be coordinated by the DEPARTMENT in cooperation with the Office of Recovery Services, and Medicaid eligibility workers. The following procedures regarding the buy-out program are:

a. the CONTRACTOR will file claims against group MCOs first before claiming services against the CONTRACTOR or other MCOs.

b. The DEPARTMENT will pay the CONTRACTOR a Medicaid premium for every buy-out Enrollee.

c. The DEPARTMENT will provide the CONTRACTOR a monthly listing of Enrollees covered under the Buy-out Program for the upcoming month.

d. On a quarterly basis, the Buy-out Program will bill the CONTRACTOR the lower of the Buy-out premium or the premium paid under this Contract when the Buy-out premium was paid to an entity other than the CONTRACTOR, i.e., the Buy-out premium is not a duplicate premium as defined in this Article VIII, Section D., Item 7. The CONTRACTOR will remit to the Buy-out Program the amount billed within 60 days of receipt of the Buy-out bill.

9. CONTRACTOR MUST PAY PROVIDER ADMINISTRATIVE FEE FOR IMMUNIZATIONS

When an Enrollee has third party coverage for immunizations, the CONTRACTOR will pay the provider the administrative fee for providing the immunization and not require the provider to bill the third party as a cost avoidance method. The CONTRACTOR may choose to pursue the third party amount for the administrative fee after payment has been made to the provider.

E. THIRD PARTY RESPONSIBILITY (INCLUDING WORKER'S COMPENSATION)

1. CONTRACTOR TO BILL USUAL AND CUSTOMARY CHARGES

When a third party has an obligation to pay for Covered Services provided by the CONTRACTOR to an Enrollee pursuant to this Contract, the CONTRACTOR will bill the third party for the usual and customary charges for Covered Services provided and costs incurred. Should any sum be recovered by the Enrollee or otherwise, from or on behalf of the person responsible for payment for the service, the CONTRACTOR will be paid out of such recovery for the charges for service provided and costs incurred by the CONTRACTOR.

2. THIRD PARTY'S OBLIGATION TO PAY FOR COVERED SERVICES

Examples of situations where a third party has an obligation to pay for Covered Services provided by the CONTRACTOR are when (a) the Enrollee is injured by a person due to the negligent or intentional acts (or omissions) of the person; or (b) the Enrollee is eligible to receive payment through Worker's Compensation Insurance. If the Enrollee does not diligently seek such recovery, the CONTRACTOR may institute such rights that it may have.

3. FIRST DOLLAR COVERAGE FOR ACCIDENTS

In addition, both parties agree that the following will apply regarding first dollar coverage for accidents: If the injured party has additional insurance, primary coverage my be given to the motor insurance effective at the time of the accident. Once the motor vehicle policy is exhausted, the CONTRACTOR will be the secondary payer and pay for all of the Enrollee's Covered Services. If medical insurance does not exist, the CONTRACTOR will be the primary payer for all Covered Services.

4. NOTIFICATION OF STOP-LOSS

The CONTRACTOR will provide ORS with quarterly updates of costs incurred by the CONTRACTOR when such costs exceed Stop Loss (reinsurance) provisions as defined in the contract between TransAmerica and the CONTRACTOR.

F. CHANGES IN COVERED SERVICES

If Covered Services are amended under the provisions of Attachment B, Article IV (Benefits), Section C, Subsection 3 of this Contract, rates may be renegotiated.

ARTICLE IX - RECORDS, REPORTS AND AUDITS

A. FEDERALLY REQUIRED REPORTS

1. FINANCIAL DISCLOSURE REPORT

If this Contract is being renewed, the CONTRACTOR will complete the Section 1318 Financial Disclosure Report for transactions (all transactions, not just Medicaid) occurring during the prior contract period, and submit it to the DEPARTMENT prior to the renewal start date. If the Contract is being renewed and the CONTRACTOR has a Medicare MCO product, the CONTRACTOR will submit the Medicare report to the DEPARTMENT upon request by the DEPARTMENT.

2. DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT

The CONTRACTOR will submit to the DEPARTMENT a copy of the "Disclosure of Ownership and Control Interest Statement" (HCFA-1513) prior to the effective date of the Contract and by April 15 of each year thereafter.

3. CHEC/EPSDT REPORTS

The CONTRACTOR agrees to act as a continuing care provider for the CHEC/EPSDT program in compliance with OBRA '89 and Social Security Act Sections 1902 (a)(43), 1905(a)(4)(B)and 1905 (r).

a. CHEC/EPSDT SCREENINGS

Annually, the CONTRACTOR will submit to the DEPARTMENT information on CHEC/EPSDT screenings to meet the Federal EPSDT reporting requirements (Form HCFA-416). The data will be in a mutually agreed upon format. The CHEC/EPSDT information is due December 31 for the prior federal fiscal year's data (October 1 through September 30).

b. IMMUNIZATION DATA

The CONTRACTOR will submit immunization data as part of the CHEC/EPSDT reporting. Enrollee name, Medicaid ID, type of immunization identified by procedure code, and date of immunization will be reported in the same format as the CHEC/EPSDT data.

B. PERIODIC REPORTS

1. ENROLLMENT, COST AND UTILIZATION REPORTS (ATTACHMENT E)

Enrollment, cost and utilization reports will be submitted on diskettes in Excel or Lotus and in the format specified in Attachment E. A hard copy of the report must be submitted as well. The DEPARTMENT will send to the CONTRACTOR a template of the Attachment E format on a diskette. The CONTRACTOR may not customize or

change the report format. The financial information for these reports will be reported as defined in HCFA Publication 75, and if applicable, HCFA 15-1. The CONTRACTOR will certify in writing the accuracy and completeness, to the best of its knowledge, of all costs and utilization data provided to the DEPARTMENT on Attachment E.

Two Attachment E reports will be submitted covering dates of service for each contract year.

a. Attachment E is due May 1 for the preceding six-month reporting period (July through December).

b. Attachment E is due November 1 for the preceding 12-month reporting period (July through June).

If necessary, the CONTRACTOR may request, in writing, an extension of the due date up to 30 days beyond the required due date. The DEPARTMENT will approve or deny the extension request writing within seven calendar days of receiving the request.

2. SEMI-ANNUAL REPORTS

The following semi-annual reports are due May 1 for the preceding six-month reporting period ending December 31 (July through December) and are due November 1 for the preceding six month period ending June 30 (January through June).

a. ORGAN TRANSPLANTS

A report of the total number of organ transplants by type of transplant.

b. OBSTETRICAL INFORMATION

A report of obstetrical information including

1) total number of obstetrical deliveries by aid category grouping
2) total number of caesarean sections and total number of vaginal deliveries;
3) total number low birth weight infants; and
4) total number of Enrollees requiring prenatal hospital admission.

c. COMPLAINTS AND FORMAL GRIEVANCES

A summary of complaints and formal grievances, by type of complaint or grievance, received by the CONTRACTOR under this Contract and actions taken to resolve such complaints and grievances

d. ABERRANT PHYSICIAN BEHAVIOR

Summary information of corrective actions taken on physicians who have been identified by the CONTRACTOR as exhibiting aberrant physician behavior and

the names of physicians who have been removed from the CONTRACTOR network due to quality concerns.

3. QUALITY ASSURANCE ACTIVITIES

Annually, the CONTRACTOR will submit their written quality improvement plan and their quality improvement work plan within 30 days of approval by the CONTRACTOR's governing body.

Annually, on November 1, the CONTRACTOR will submit a report that identifies the CONTRACTOR's internal quality assurance activities, results thereof, and corrective actions taken during the previous contract year ending (July through June).

4. HEDIS

Audited Health Plan Employer Data and Information Set (HEDIS) performance measures will cover services rendered during each calendar year and will be reported as set forth in State rule by the Office of Health Data Analysis. For example, calendar year 1997 HEDIS measures will be reported in 1998.

5. ENCOUNTER DATA

Encounter data, as defined in the DEPARTMENT's Encounter Data Technical Manual, is due (including all replacements) nine months after the end of the quarter being reported. Encounter data will be submitted in accordance with the instructions detailed in the Encounter Data User Manual for dates of service beginning July 1, 1997.

6. DOCUMENTS DUE PRIOR TO QUALITY MONITORING REVIEWS

The following documents are due on request or at least 60 days prior to the DEPARTMENT's quality assurance monitoring review unless the DEPARTMENT has already received documents that are in effect:

a. the CONTRACTOR's most current (may be in draft stage) written plan for quality improvement;
b. the CONTRACTOR's most current (may be in draft stage) annual quality improvement work plan;
c. the CONTRACTOR's reports that identify over and under utilization of covered services and efforts put in place to resolve inappropriate over utilization and under utilization;
d. the CONTRACTOR's process for identifying and correcting aberrant provider behavior; and
e. other information requested by the DEPARTMENT to facilitate the DEPARTMENT's review of the CONTRACTOR's compliance to standards defined in the Division of Health Care Financing's MCO Quality Assurance Monitoring Plan (Attachment G).

The above documents will show evidence of a well defined, organized program designed to improve client care.

7. AUDIT OF ABORTIONS, STERILIZATIONS AND HYSTERECTOMIES

The CONTRACTOR must conduct an annual audit of all abortions in addition to an audit of a sample of sterilizations and hysterectomies as set by the DEPARTMENT that the CONTRACTOR providers performed during each contract year to assure compliance of its providers with all Federal and State requirements related to Federal financial participation of abortions. On November 1 of each year, the CONTRACTOR will submit to the DEPARTMENT the results of the audit for the previous calendar year.

8. DEVELOPMENT OF NEW REPORTS

Any new reports/data requirements mandated by the DEPARTMENT will be mutually developed by the DEPARTMENT and the CONTRACTOR.

C. RECORD SYSTEM REQUIREMENTS

In accordance with Section 4752 of OBRA '90 (amended section 1903 (m)(2)(A) of the Social Security Act), the CONTRACTOR agrees to maintain sufficient patient encounter data to identify the physician who delivers Covered Services to Enrollees. The CONTRACTOR agrees to provide this encounter data, upon request of the DEPARTMENT, within 30 days of the request.

D. MEDICAL RECORDS

The CONTRACTOR agrees that medical records are considered confidential information and agrees to follow Federal and State confidentiality requirements.

The CONTRACTOR will require that subcontracting providers maintain a medical record keeping system through which all pertinent information relating to the medical management of the Enrollee is maintained, organized, and is readily available to appropriate professionals. Notwithstanding any other provision of this Contract to the contrary, medical records covering Enrollees will remain the property of the CONTRACTOR provider, and the CONTRACTOR provider will respect every Enrollee's privacy by restricting the use and disclosure of information in such records to purposes directly connected with the Enrollee's health care and administration of this Contract. The CONTRACTOR will use and disclose information pertaining to individual Enrollees and prospective Enrollees only for purposes directly connected with the administration of the Medicaid Program and this Contract.

E. AUDITS

1. RIGHT OF DEPARTMENT AND HCFA TO AUDIT

The DEPARTMENT and the Secretary of the Department of Health and Human Services within HCFA will have the right to audit and inspect any books and records of the CONTRACTOR and its subcontractors pertaining (I) to the ability of the

CONTRACTOR to bear the risk of potential financial losses, or (II) to evaluate services performed or determinations of amounts payable under the Contract.

2. INFORMATION TO DETERMINE ALLOWABLE COSTS

The CONTRACTOR will make available to the DEPARTMENT all reasonable and related financial, statistical, clinical or other information needed for the determination of allowable costs to the Medicaid program for "related party/home office" transactions as defined in HCFA 15-1. These records are to be made available in Utah or the CONTRACTOR will pay the increased cost (incremental travel, per diem, etc.) of auditing at the out-of-state location. The cost to the CONTRACTOR will include round-trip travel and two days per diem/lodging. Additional travel costs of the site audit will be shared equally by the CONTRACTOR and the DEPARTMENT.

3. MANAGEMENT AND UTILIZATION AUDITS

The MCO will allow the DEPARTMENT and the Department of Health and Human Services within HCFA to perform audits for identification and collection of management data, including Enrollee satisfaction data, quality of care data, patient outcome cost, and utilization data, which will include patient profiles, exception reports, etc. The CONTRACTOR will provide all data required by the DEPARTMENT or the independent quality review examiners in performance of these audits. Prior to beginning any audit, the DEPARTMENT will give the CONTRACTOR reasonable notice of audit, and the DEPARTMENT will be responsible for costs of its auditors or representatives.

F. INDEPENDENT QUALITY REVIEW

1. IN GENERAL

Pursuant to Section 1932(c)(2)(A) of the Social Security Act the DEPARTMENT will provide for an annual external independent review conducted by a qualified independent entity of the quality outcomes and timeliness of, and access to Covered Services. The CONTRACTOR will support the annual external independent review.

The DEPARTMENT will choose an agency to perform an annual independent quality review pursuant to federal law and will pay for such review. The CONTRACTOR will maintain all clinical and administrative records for use by the quality review contractor.

The CONTRACTOR agrees to support quality assurance reviews, focused studies and other projects performed for the DEPARTMENT by the external quality review organization (EQRO). The purpose of the reviews and studies are to comply with federal requirements for an annual independent audit of the quality outcomes and timeliness of, and access to Covered Services. The external independent reviews are conducted by the EQRO, with the advice, assistance, and cooperation of a planning team composed of representatives from the CONTRACTOR, the EQRO and the DEPARTMENT with final approval by the DEPARTMENT.

2. SPECIFIC REQUIREMENTS

a. LIAISON FOR ROUTINE COMMUNICATION

The CONTRACTOR will designate an individual to serve as liaison with the EQRO for routine communication with the EQRO.

b. REPRESENTATIVE TO ASSIST WITH PROJECTS

The CONTRACTOR will designate a minimum of two representatives (unless one individual can service both functions) to serve on the planning team for each EQRO project. Representatives will include a quality improvement representative and a data representative. The planning team is a joint collaborative forum between DEPARTMENT staff, the EQRO and the CONTRACTOR. The role of the planning team is to participate in the process and completion of EQRO projects.

c. COPIES AND ON-SITE ACCESS

The CONTRACTOR will be responsible for obtaining copies of Enrollee information and facilitating on-site access to Enrollee information as needed by the EQRO. Such information will be used to plan and conduct projects and to investigate complaints and grievances. Any associated copying costs are the responsibility of the CONTRACTOR. Enrollee information includes medical records, administrative data such as, but not limited to, enrollment information and claims, nurses' notes, medical logs, etc. of the CONTRACTOR or its providers.

d. FORMAT OF ENROLLEE FILES

The CONTRACTOR will provide Enrollee information in a mutually agreed upon format compatible for the EQRO's use, and in a timely fashion to allow the EQRO to select cases for its review.

e. TIME-FRAME FOR PROVIDING DATA

The CONTRACTOR will provide data requests to the EQRO within 15 working days of the written request from the EQRO and will provide medical records within 30 working days of the written request from the EQRO. Requests for extensions of these time frames will be reviewed and approved or disapproved by the DEPARTMENT on a case-by-case basis.

f. WORK SPACE FOR ON-SITE REVIEWS

The CONTRACTOR will assure that the EQRO staff and consultants have adequate work space, access to a telephone and copy machines at the time of review. The review will be performed during agreed-upon hours.

g. STAFF ASSISTANCE DURING ON-SITE VISITS

The CONTRACTOR will assign appropriate person(s) to assist the EQRO personnel conduct the reviews during on-site visits and to participate in an informal discussion of screening observations at the end of each on-site visit, if necessary.

h. CONFIDENTIALITY

For information received from the EQRO, the CONTRACTOR will comply with the Department of Health and Human Services regulations relating to confidentiality of data and information (42 CFR Part 476.107 and 476.108).

ARTICLE X - SANCTIONS

The DEPARTMENT may impose intermediate sanctions on the CONTRACTOR if the CONTRACTOR defaults in any manner in the performance of any obligation under this Contract including but not limited to the following situations:

(1) the CONTRACTOR fails to substantially provide Medically Necessary Covered Services to Enrollees;

(2) the CONTRACTOR imposes premiums or charges Enrollees in excess of the premiums or charges permitted under this Contract;

(3) the CONTRACTOR acts to discriminate among Enrollees on the basis of their health status or requirements for health care services, including expulsion or refusal to re-enroll an individual, except as permitted by Title XIX, or engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment with the MCO by potential enrollees whose medical condition or history indicates a need for substantial future medical services;

(4) the CONTRACTOR misrepresents or falsifies information furnished to the Health Care Financing Administration, the DEPARTMENT, an Enrollee, potential Enrollee or health care provider;

(5) the CONTRACTOR fails to comply with the physician incentive requirements under Section 1903(m)(2)(A)(x) of the Social Security Act.

(6) the CONTRACTOR distributed directly or through any agent or independent contractor marketing materials that contain false or misleading information.

The DEPARTMENT must follow the 1997 Balance Budget Act guidelines on the types of intermediate sanctions the DEPARTMENT may impose, including civil monetary penalties, the appointment of temporary management, and suspension of payment.

ARTICLE XI - TERMINATION OF THE CONTRACT

A. AUTOMATIC TERMINATION

This Contract will automatically terminate June 30, 2004.

B. OPTIONAL YEAR-END TERMINATION

At the end of each contract year, either party may terminate the Contract without cause for subsequent years by giving the other party written notice of termination at least 90 days prior to the end of the contract year (July 1 through June 30).

C. TERMINATION FOR FAILURE TO AGREE UPON RATES

At least 60 days prior to the end of each contract year, the parties will meet and negotiate in good faith the rates (Attachment F) applicable to the upcoming year. If the parties cannot agree upon future rates by the end of the contract year, then either party may terminate the Contract for subsequent years by giving the other party written notice of termination and the termination will become effective 90 days after receipt of the written notice of termination.

D. EFFECT OF TERMINATION

1. COVERAGE

Inasmuch as the CONTRACTOR is paid on a monthly basis, the CONTRACTOR will continue providing the Covered Services required by this Contract until midnight of the last day of the calendar month in which the termination becomes effective. If an Enrollee is a patient in an inpatient hospital setting during the month in which termination becomes effective, the CONTRACTOR is responsible for the entire hospital stay including physician charges until discharge or thirty days following termination, whichever occurs first.

2. ENROLLEE NOT LIABLE FOR DEBTS OF CONTRACTOR OR ITS SUBCONTRACTORS

If the CONTRACTOR or one of its subcontractors becomes insolvent or bankrupt, the Enrollees will not be liable for the debts of the CONTRACTOR or its subcontractor. The CONTRACTOR will include this term in all of its subcontracts.

3. INFORMATION FOR CLAIMS PAYMENT

The CONTRACTOR will promptly supply to the DEPARTMENT all information necessary for the reimbursement of any Medicaid claims not paid by the CONTRACTOR.

4. CHANGES IN ENROLLMENT PROCESS

The CONTRACTOR will be advised of anticipated changes in policies and procedures as they relate to the enrollment process and their comments will be solicited. The

CONTRACTOR agrees to be bound by such changes in policies and procedures unless they are not agreeable to the CONTRACTOR, in which case the CONTRACTOR may terminate the Contract in accordance with the Contract termination provisions.

5. HEARING PRIOR TO TERMINATION

Regarding the General Provisions, Article XVII (Default, Termination, & Payment Adjustment), item 3, if the CONTRACTOR fails to meet the requirements of the Contract, the DEPARTMENT must give the CONTRACTOR a hearing prior to termination. Enrollees must be informed of the hearing and will be allowed to disenroll from the MCO without cause.

E. ASSIGNMENT

Assignment of any or all rights or obligations under this Contract without the prior written consent of the DEPARTMENT is prohibited. Sale of all or any part of the rights or obligations under this Contract will be deemed an assignment. Consent may be withheld in the DEPARTMENT's sole and absolute discretion.

ARTICLE XII - MISCELLANEOUS

A. INTEGRATION

This Contract contains the entire agreement between the parties with respect to the subject matter of this Contract. There are no representations, warranties, understandings, or agreements other than those expressly set forth herein. Previous contracts between the parties hereto and conduct between the parties which precedes the implementation of this Contract will not be used as a guide to the interpretation or enforcement of this Contract or any provision hereof.

B. ENROLLEES MAY NOT ENFORCE CONTRACT

Although this Contract relates to the provision of benefits for Enrollees and others, no Enrollee is entitled to enforce any provision of this Contract against the CONTRACTOR nor will any provision of this Contract be constructed to constitute a promise by the CONTRACTOR to any Enrollee or potential Enrollee.

C. INTERPRETATION OF LAWS AND REGULATIONS

The DEPARTMENT will be responsible for the interpretation of all federal and State laws and regulations governing or in any way affecting this Contract. When interpretations are required, the CONTRACTOR will submit written requests to the DEPARTMENT. The DEPARTMENT will retain full authority and responsibility for the administration of the Medicaid program in accordance with the requirements of Federal and State law.

D. ADOPTION OF RULES

Adoption of rules by the DEPARTMENT, subsequent to this amendment, and which govern the Medicaid program, will be automatically incorporated into this Contract upon receipt by the CONTRACTOR of written notice thereof.

ARTICLE XIII - EFFECT OF GENERAL PROVISIONS

If there is a conflict between these Special Provisions (Attachment B) or the General Provisions (Attachment A), then these Special Provisions will control.

ATTACHMENT C - COVERED SERVICES

A. IN GENERAL

The CONTRACTOR will provide the following benefits to Enrollees in accordance with Medicaid benefits as defined in the Utah State Plan subject to the exception or limitations as noted below. The DEPARTMENT reserves the right to interpret what is in the State plan. Medicaid services can only be limited through utilization criteria based on Medical Necessity. The CONTRACTOR will provide at least the following benefits to Enrollees.

The CONTRACTOR is responsible to provide or arrange for all Medically Necessary Covered Services on an emergency basis 24 hours each day, seven days a week. The CONTRACTOR is responsible for payment for all covered Emergency Services furnished by providers that do not have arrangements with the CONTRACTOR.

B. HOSPITAL SERVICES

1. INPATIENT HOSPITAL

Services furnished in a licensed, certified hospital.

2. OUTPATIENT HOSPITAL

Services provided to Enrollees at a licensed, certified hospital who are not admitted to the hospital.

3. EMERGENCY DEPARTMENT SERVICES

Emergency Services provided to Enrollees in designated hospital emergency departments.

C. PHYSICIAN SERVICES

Services provided directly by licensed physicians or osteopaths, or by other licensed professionals such as physician assistants, nurse practitioners, or nurse midwives under the physician's or osteopath's supervision.

D. GENERAL PREVENTIVE SERVICES

The CONTRACTOR must develop or adopt practice guidelines consistent with current standards of care, as recommended by professional groups such as the American Academy of Pediatric and the U.S. Task Force on Preventive Care.

A minimum of three screening programs for prevention or early intervention (e.g. Pap Smear, diabetes, hypertension).

E. VISION CARE

Services provided by licensed ophthalmologists or licensed optometrists, and opticians within their scope of practice. Eyeglasses will be provided to eligible recipients based on medical necessity. Services include, but are not limited to, the following:

1. Eye refractions, examinations
2. Laboratory work
3. Lenses
4. Eyeglass Frames
5. Repair of Frames
6. Repair or Replacement of Lenses
7. Contact Lenses (when Medically Necessary)

F. LAB AND RADIOLOGY SERVICES

Professional and technical laboratory and X-ray services furnished by licensed and certified providers. All laboratory testing sites, including physician office labs, providing services under this Contract will have either a Clinical Laboratory Improvement Amendments (CLIA) certificate of Waiver or a certificate of registration along with a CLIA identification number.

Those laboratories with certificates of waiver will provide only the eight types of tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests.

G. PHYSICAL AND OCCUPATIONAL THERAPY

1. PHYSICAL THERAPY

Treatment and services provided by a licensed physical therapist. Treatment and services must be authorized by a physician and include services prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law and provided to an Enrollee by or under the direction of a qualified physical therapist. Necessary supplies and equipment will be reviewed for medical necessity and follow the criteria of the R414.12 rule.

2. OCCUPATIONAL THERAPY

Treatment of services provided by a licensed occupational therapist. Treatment and services must be authorized by a physician and include services prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law and provided to an Enrollee by or under the direction of a qualified occupational therapist. Necessary supplies and equipment will be reviewed for medical necessity and follow the criteria of the R414.12 rule.

H. SPEECH AND HEARING SERVICES

Services and appliances, including hearing aids and hearing aid batteries, provided by a licensed medical professional to test and treat speech defects and hearing loss.

I. PODIATRY SERVICES

Services provided by a licensed podiatrist.

J. END STAGE RENAL DISEASE - DIALYSIS

Treatment of end stage renal dialysis for kidney failure. Dialysis is to be rendered by a Medicare-certified Dialysis facility.

K. HOME HEALTH SERVICES

Home health services are defined as intermittent nursing care provided by certified nursing professionals (registered nurses, licensed practical nurses, and home health aides) in the client's home when the client is homebound or semi-homebound. Home health care must be rendered by a Medicare-certified Home Health Agency that has a surety bond.

Personal care services as defined in the DEPARTMENT's Medicaid Personal Care Provider Manual are included in this Contract. Personal care services may be provided by a State licensed home health agency.

L. HOSPICE SERVICES

Services delivered to terminally ill patients (six months life expectancy) who elect palliative versus aggressive care. Hospice care is to be rendered by a Medicare-certified hospice.

M. PRIVATE DUTY NURSING

Services provided by licensed nurses for ventilator-dependent children and technology-dependent adults in their home in lieu of hospitalization if Medically Necessary, feasible, and safe to be provided in the patient's home. Requests for continuous care will be evaluated on a case by case basis and must be approved by the CONTRACTOR.

N. MEDICAL SUPPLIES AND MEDICAL EQUIPMENT

This Covered Service includes any necessary supplies and equipment used to assist the Enrollee's medical recovery, including both durable and non-durable medical supplies and equipment, and prosthetic devices. The objective of the medical supplies program is to provide supplies for maximum reduction of physical disability and restore the Enrollee to his or her best functional level. Medical supplies may include any necessary supplies and equipment recommended by a physical or occupational therapist, but should be ordered by a physician. Durable medical equipment includes, but is not limited to, prosthetic devices and specialized wheelchairs. Durable medical equipment and supplies must be provided by a durable medical

equipment supplier that has a surety bond. Necessary supplies and equipment will be reviewed for medical necessity and follow the criteria of the R414.12 of the Utah Administrative Code, with the exception of criteria concerning long term care since long term care services are not covered under the Contract.

O. ABORTIONS AND STERILIZATIONS

These services are provided to the extent permitted by Federal and State law and must meet the documentation requirement of 42 CFR 441, Subparts E and F. These requirements must be met regardless of whether Medicaid is primary or secondary payer.

P. TREATMENT FOR SUBSTANCE ABUSE AND DEPENDENCY

Treatment will cover medical detoxification for alcohol or substance abuse conditions. Medical services including hospital services will be provided for the medical non-psychiatric aspects of the conditions of alcohol/drug abuse.

Q. ORGAN TRANSPLANTS

The following transplantations are covered for all Enrollees: Kidney, liver, cornea, bone marrow, heart, intestine, lung, pancreas, small bowel, combination heart/lung, combination intestine/liver, combination kidney/pancreas, combination liver/kidney, multi visceral, and combination liver/small bowel unless amended under the provisions of Attachment B, Article IV (Benefits), Section C, Subsection 3 of this Contract.

R. OTHER OUTSIDE MEDICAL SERVICES

The CONTRACTOR, at its discretion and without compromising quality of care, may choose to provide services in Freestanding Emergency Centers, Surgical Centers and Birthing Centers.

S. LONG TERM CARE

The CONTRACTOR may provide long term care for Enrollees in skilled nursing facilities requiring such care as a continuum of a medical plan when the plan includes a prognosis of recovery and discharge within thirty (30) days or less. When the prognosis of an Enrollee indicates that long term care (over 30 days) will be required, the CONTRACTOR will notify the DEPARTMENT and the skilled nursing facility of the prognosis determination and will initiate disenrollment to be effective on the first day of the month following the prognosis determination. Skilled nursing care is to be rendered in a skilled nursing facility which meets federal regulations of participation.

T. TRANSPORTATION SERVICES

Ambulance (ground and air) service for medical emergencies. The CONTRACTOR is also responsible to pay for authorized emergency transportation for an illness or accident episode which, upon subsequent medical evaluation at the hospital, is determined to be psychiatric-related. The CONTRACTOR will submit its emergency transportation policy to the

DEPARTMENT for review. The CONTRACTOR is not responsible for transporting an Enrollee from an acute care facility to another acute care facility for a psychiatric admission. The CONTRACTOR's scope of coverage for emergency transportation services is limited to the same scope of coverage as defined in the transportation Medicaid provider manual.

U. SERVICES TO CHEC ENROLLEES

1. CHEC SERVICES

The CONTRACTOR will provide to CHEC Enrollees preventive screening services and other necessary medical care, diagnostic services, treatment, and other measures necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State Medicaid Plan. The CONTRACTOR is not responsible for home and community-based services available through Utah's Home and Community-Based waiver programs.

The CONTRACTOR will provide the full early and periodic screening, diagnosis, and treatment services to all eligible children and young adults up to age 21 in accordance with the periodicity schedule as described in the Utah CHEC Provider Manual. All children between six months and 72 months must be screened for blood lead levels.

2. CHEC POLICIES AND PROCEDURES

The CONTRACTOR agrees to have written policies and procedures for conducting tracking, follow-up, and outreach to ensure compliance with the CHEC periodicity schedules. These policies and procedures will emphasize outreach and compliance monitoring for children and young adults, taking into account the multi-lingual, multicultural nature as well as other unique characteristics of the CHEC Enrollees.

V. FAMILY PLANNING SERVICES

This service includes disseminating information, counseling, and treatments relating to family planning services. All services must be provided by or authorized by a physician, certified nurse midwife, or nurse practitioner. All services must be provided in concert with Utah law.

Birth control services include information and instructions related to the following:

1. Birth control pills;
2. Norplant;
3. Depo Provera;
4. IUDs;
5. Barrier methods including diaphragms, male and female condoms, and cervical caps;
6. Vasectomy or tubal ligations; and
7. Office calls, examinations or counseling related to contraceptive devices.

W. HIGH-RISK PRENATAL SERVICES

1. IN GENERAL - ENSURE SERVICE ARE APPROPRIATE AND COORDINATED

The CONTRACTOR must ensure that high risk pregnant Enrollees receive an appropriate level of quality perinatal care that is coordinated, comprehensive and continuous either by direct service or referral to an appropriate provider or facility. In the determination of the provider and facility to which a high risk prenatal Enrollee will be referred, care must be taken to ensure that the provider and facility both have the appropriate training, expertise and capability to deliver the care needed by the Enrollee and her fetus/infant. Although many complications in perinatal health cannot be anticipated, most can be identified early in pregnancy. Ideally, preconceptional counseling and planned pregnancy are the best ways to assure successful pregnancy outcome, but this is often not possible. Provision of routine preconceptional counseling must be made available to those women who have conditions identified as impacting pregnancy outcome, i.e., diabetes mellitus, medications which may result in fetal anomalies or poor pregnancy outcome, or previous severe anomalous fetus/infant, among others.

2. RISK ASSESSMENT

a. CRITERIA

Enrollees who are pregnant should be risk assessed for medical and psychosocial conditions which may contribute to a poor birth outcome at their first prenatal visit, preferably in the first trimester. The patient who is determined not to be at high risk should be evaluated for change in risk status throughout her pregnancy. There are a number of complex systems to determine how to assess the risk of pregnancies. The DEPARTMENT has developed a risk assessment tool available through the Division of Community and Family Health Services which is available upon request.

b. RECOMMENDED PRENATAL SCREENING

The DEPARTMENT recommends prenatal screening of every woman for hepatitis B surface antigen (HBsAg) to identify all those at high risk for transmitting the virus to their newborns. When a woman is found to be HBsAg-positive, the CONTRACTOR will provide HBIG and HB vaccine at birth. Initial treatments should be given during the first 12 hours of life.

c. CLASSIFICATION

Upon identification of pregnancy or the development of a risk factor, each patient should be assigned a classification as outlined below.

1) Group I
Group I patients have no significant risk factors. They may receive obstetrical care by an obstetrician/gynecologist (OB/GYN), family

practitioner or certified nurse midwife.

2) Group II
Group II patients have the following risk factors, and require consultation (consultation may be either by telephone or in person, as appropriate) with an OB/GYN:

i. pregnancy beyond 42 weeks
ii. preterm labor in the current pregnancy less than 34 weeks
iii. fetal malpresentation at 37 weeks gestation and beyond*
iv. oxytocin or antepartum prostaglandin use is contemplated*
v. arrest of dilatation in labor, or arrest of descent in labor*
vi. bleeding in labor, beyond bloody show*
vii. abnormal fetal heart rate pattern potentially requiring specific intervention*
viii. chorioamnionitis*
ix. preeclampsia
x. VBAC*

*Criteria do not apply if family physician has cesarean privileges.

3. Group III
Group III patients have the following risk factors, and require consultation by a Maternal Fetal Medicine (MFM) specialist (board certified perinatologist)

i. intrauterine growth restriction prior to 37 weeks
ii. patient at increased risk for fetal anomaly (including teratogen exposure)
iii. patient has known fetal anomaly

iv. preterm delivery (less than 36 weeks) in a prior pregnancy

v. abnormal serum screening

vi. previous child with congenital anomaly
vii. antibody sensitization
viii. anemia, excluding iron deficiency
ix. significant concurrent medical illness
x. spontaneous premature rupture of the membranes, not in labor (less than 34 weeks)
xi. history of thromboembolic disease
xii. thromboembolic disease in current pregnancy
xiii. habitual pregnancy loss (3 or more consecutive losses)
xiv. two or more previous stillbirths or neonatal deaths

4. Group IV
Group IV patients have the following risk factors, and require total obstetric care by an OB/GYN, or co-management with an OB/GYN or MFM

i. any significant medical complication, including patients with insulin dependent diabetes millitus, chronic hypertension requiring medication, maternal neoplastic disease
ii. twins
iii. known or suspected cervical incompetence
iv. placenta previa beyond 28 week gestation
v. severe preeclampsia

5. Group V

Group V patients have the following risk factors, and require total obstetric care by a MFM (exceptions may be made by a regional MFM specialist, on a case-by-case basis, after MFM consultation)

i. triplets and above
ii. patient has an organ transplant (except cornea)
iii. diabetes mellitus with severe renal impairment
iv. cardiac disease, not functional class I, including all pulmonary hypertension
v. twin-twin transfusion syndrome
vi. patient requires fetal surgical procedure

3. PRENATAL INITIATIVE PROGRAM

Prenatal services provided directly or through agreements with appropriate providers includes those services covered under Medicaid's Prenatal Initiative Program which includes the following enhanced services for pregnant women:

a. perinatal care coordination
b. prenatal and postnatal home visits
c. group prenatal and postnatal education
d. nutritional assessment and counseling
e. prenatal and postnatal psychosocial counseling

Psychosocial counseling is a service designed to benefit the pregnant client by helping her cope with the stress that may accompany her pregnancy. Enabling her to manage this stress improves the likelihood that she will have a healthy pregnancy. This counseling is intended to be short term and directly related to the pregnancy. However, pregnant women who are also suffering from a serious emotional or mental illness should be referred to an appropriate mental health care provider.

X. SERVICES FOR CHILDREN WITH SPECIAL NEEDS

1. IN GENERAL

In addition to primary care, children with chronic illnesses and disabilities need specialized care provided by trained experienced professionals. Since early diagnosis and intervention will prevent costly complications later on, the specialized care must be provided in a timely manner. The specialized care must comprehensively address all

areas of need to be most effective and must be coordinated with primary care and other services to be most efficient. The children's families must be involved in the planning and delivery of the care for it to be acceptable and successful.

2. SERVICES REQUIRING TIMELY ACCESS

All children with special health care needs must have timely access to the following services:

a. Comprehensive evaluation for the condition.

b. Pediatric subspecialty consultation and care appropriate to the condition.

c. Rehabilitative services provided by professionals with pediatric training in areas such as physical therapy, occupational therapy and speech therapy.

d. Durable medical equipment appropriate for the condition.

e. Care coordination for linkage to early intervention, special education and family support services and for tracking progress.

In addition, children with the conditions marked by * below must have timely access to coordinated multispecialty clinics, when Medically Necessary, for their disorder.

3. DEFINITION OF CHILDREN WITH SPECIAL HEALTH CARE NEEDS

The definition of children with special health needs includes, but is not limited to, the following conditions:

a. Nervous System Defects such as
Spina Bifida*
Sacral Agenesis*
Hydrocephalus

b. Craniofacial Defects such as
Cleft Lip and Palate*
Treacher - Collins Syndrome

c. Complex Skeletal Defects such as
Arthrogryposis*
Osteogenesis Imperfecta*
Phocomelia*

d. Inborn Metabolic Disorders such as
Phenylketonuria*
Galactosemia*

e. Neuromotor Disabilities such as
   Cerebral palsy*
   Muscular Dystrophy*
   Complex Seizure Disorders

f. Congenital Heart Defects

g. Genetic Disorders such as
   Chromosome Disorders
   Genetic Disorders

h. Chronic Illnesses such as
   Cystic Fibrosis
   Hemophilia
   Rheumatoid Arthritis
   Bronchopulmonary Dysplasia
   Cancer
   Diabetes
   Nephritis
   Immune Disorders

i. Developmental Disabilities with multiple or global delays in development such as Down Syndrome or other conditions associated with mental retardation.

The CONTRACTOR agrees to cover all Medically Necessary services for children with special health care needs such as the ones listed above. The CONTRACTOR further agrees to cooperate with the DEPARTMENTS quality assurance monitoring for this population by providing requested information.

Y. MEDICAL AND SURGICAL SERVICES OF A DENTIST

1. WHO MAY PROVIDE SERVICES

Under Utah law, medical and surgical services of a dentist may be provided by either a physician or a doctor of dental medicine or dental surgery.

2. UNIVERSE OF COVERED SERVICES

Medical and surgical services that under Utah law may be provided by a physician or a doctor of dental medicine or dental surgery, are covered under the Contract.

3. SERVICES SPECIFICALLY COVERED

Palliative care and pain relief for severe mouth or tooth pain in an emergency room are covered services. The CONTRACTOR is responsible for authorized/approved medical services provided by oral surgeons consistent with injury, accident, or disease including, but not limited to, removal of tumors in the mouth, setting and wiring a fractured jaw. If

the emergency room physician determines that it is not an emergency and the client requires services at a lesser level, the provider should refer the client to a dentist for treatment. If the dental-related problem is serious enough for the client to be admitted to the hospital the CONTRACTOR is responsible for coverage of the inpatient hospital stay.

4. DENTAL SERVICES NOT COVERED

The CONTRACTOR is not responsible for services that are usually considered dental such as fillings, pulling of teeth, treatment of abscess or infection, orthodontics, and pain relief when provided by a dentist in the office or in an outpatient setting such as surgical center or scheduled same day surgery in a hospital.

Z. DIABETES EDUCATION

The CONTRACTOR shall provide diabetes self-management education from a Utah certified or American Diabetes Association recognized program when an Enrollee:

1. has recently been diagnosed with diabetes, or

2. is determined by the health care professional to have experienced a significant change in symptoms, progression of the disease or health condition that warrants changes in the Enrollee's self-management plan, or

3. is determined by the health care professional to require re-education or refresher training.

AA. HIV PREVENTION

The CONTRACTOR shall have in place the following:

1. GENERAL PROGRAM

The CONTRACTOR must have educational methods for promoting HIV prevention to Enrollees. HIV prevention information, both primary (targeted to uninfected Enrollees), as well as secondary (targeted to those Enrollees with HIV) should must be culturally and linguistically appropriate. All Enrollees should be informed of the availability of both in-plan HIV counseling and testing services, as well as those available from Utah State-operated programs.

2. FOCUSED PROGRAM FOR WOMEN

Special attention should be paid identifying HIV+ women and engaging them in routine care in order to promote treatment including, but not limited to, antiretroviral therapy during pregnancy.

ATTACHMENT D - QUALITY ASSURANCE AND UTILIZATION MANAGEMENT

A. QUALITY OF CARE

1. IN GENERAL

The CONTRACTOR will establish a written quality assurance plan, an annual quality improvement work plan, and a plan for utilization management for covered services. All plans should show evidence of a well defined, organized program designed to improve client care, to monitor over utilization and under utilization, and to identify and correct aberrant provider behavior. Prior to the effective date of the Contract, all plans must be reviewed by the DEPARTMENT.

2. REQUIRED ELEMENTS OF PLANS

Together, all plans will:

a. Show systematic surveillance and assessment of all modes of delivery by appropriate health professionals;

b. Show mechanisms and/or designation of individuals with specific responsibility to resolve identified problems;

c. Provide for monitoring to assure that resolution is achieved and maintained with documentary evidence of same;

d. Require use of written, clinically sound criteria to enhance client services and assure sound clinical performance by health care deliveries;

e. Result in identification of important client service problems or potential problems including utilization of service patterns by provider and recipient;

f. Monitor the effectiveness of the client grievance process; and

g. Be in accordance with the Code of Federal Regulations, Title 42, and the Utah State Title XIX Plan. Adherence to the points and conditions of Attachment D will assure compliance with this requirement unless modified by addendum to this attachment for specific services.

B. INTERNAL MONITORING

1. IN GENERAL

In order to assess medical necessity, appropriateness, quality of care, and timeliness of service, the CONTRACTOR will monitor services to all Enrollees in accordance with the CONTRACTOR's written quality assurance plans.

2. ELEMENTS OF INTERNAL QUALITY ASSURANCE PLAN

The CONTRACTOR will provide for an internal quality assurance plan that:

a. Is consistent with the utilization control requirement of part 456 of 42 CFR;

b. Provides for review by appropriate health professionals of the process followed in providing health services;

c. Provides for systematic data collection of performance and patient results;

d. Provides for interpretation of this data to the practitioners; and

e. Provides for making needed changes.

3. DEMONSTRATION OF HIGH QUALITY HEALTH CARE

Provision of high-quality health care services will be demonstrated by:

a. Adequate and appropriate diagnostic procedures;

b. Treatment necessary and relevant to the working diagnosis;

c. Appropriate consultation(s);

d. Patient compliance with treatment;

e. Continuity of care with adequate transfer of information between health care providers;

f. Appropriate, accurate, and complete client records;

g. Patient satisfaction;

h. Accessibility and availability of services including Emergency Services;

i. Patient instruction in self-care, prevention and the use of medications and therapies.

j. The utilization of the least invasive and most cost-effective resources when possible;

k. The use of ancillary services consistent with patients' needs; and

l. Conducting Enrollee satisfaction surveys at least annually.

C. QUALITY ASSURANCE MONITORING

1. OBJECTIVE

The objective of the quality assurance monitoring process is to ensure compliance to State and Federal policies, rules and regulations; adherence to community standards; and integrity of Medicaid payments made for medical services provided to eligible recipients under the CONTRACTOR.

2. MONITORING OF PROVIDERS AND RECIPIENTS NECESSARY TO ACHIEVE OBJECTIVE

a. The CONTRACTOR will report all cases of program abuse or suspected abusive or fraudulent behavior by either providers or recipients.

b. The CONTRACTOR will inform the DEPARTMENT in writing when a provider is removed from the CONTRACTOR's panel for reasons relating to quality of care concerns.

c. The CONTRACTOR will take appropriate, effective and coordinated action on all such information.

d. The CONTRACTOR will make reasonable efforts, pursuant to the CONTRACTOR's standard procedures, to correct the behavior of providers or recipients violating program regulations or exhibiting inappropriate program utilization;

e. Report to the DEPARTMENT, in writing, any providers or recipients who fail to correct aberrant practices and continue to abuse the program;

f. Ensure that funds do not continue to be disbursed in the presence of evidence indicating such practices; and

g. Attempt to recover any funds improperly disbursed, as a result of such practices.

D. THE DEPARTMENT'S QUALITY ASSURANCE MONITORING PLAN

The DEPARTMENT will review the CONTRACTOR for compliance to standards defined in the Division of Health Care Financing's MCO Quality Assurance Monitoring Plan (Attachment G).

E. CORRECTIVE ACTION

1. WHEN CORRECTIVE ACTIONS ARE NECESSARY

The CONTRACTOR agrees to implement corrective action as specified by the DEPARTMENT when quality assurance monitoring including but not limited to site reviews, CONTRACTOR documentation reviews, data analysis, medical audits, or complaints/grievances, determines the need for such corrective action. In addition, if the

DEPARTMENT determines that the CONTRACTOR has not provided services in accordance with the Contract or within expected professional standards, the DEPARTMENT will request in writing that the CONTRACTOR correct deficiencies or identified problems by developing a corrective action plan.

2. INITIAL RESPONSE BY CONTRACTOR

The CONTRACTOR has 20 working days from the date the DEPARTMENT mails, through certified mail, its written request for the CONTRACTOR to respond to the problems identified and will either

a. submit a corrective action plan,

b. submit a letter summarizing the CONTRACTOR's disagreements with the DEPARTMENT's findings, or

c. request, in writing, an extension of the 20-day time frame. The CONTRACTOR may only request an extension if it determines it will conduct a medical records review or there are other extenuating circumstances.

If the CONTRACTOR fails to respond in one of the above ways, the CONTRACTOR will be subject the following sanction:

A $500 penalty for each working day, beginning on the first day after the 20-day time period has expired, and continuing until the day a corrective action plan is submitted to the DEPARTMENT.

3. SUBMISSION OF CORRECTIVE ACTION TO DEPARTMENT

a. ACCEPTANCE OF CORRECTIVE ACTION PLAN

If the CONTRACTOR submits a corrective action plan to the DEPARTMENT within 20 working days (or other agreed upon time frame) and the DEPARTMENT accepts the corrective action plan, the DEPARTMENT will send written notice to the CONTRACTOR officially approving the corrective action plan.

b. WHEN CORRECTIVE ACTION PLAN REQUIRES REVISIONS

If the CONTRACTOR submits a corrective action plan, but the DEPARTMENT determines the corrective action plan requires revisions, the CONTRACTOR will have 20 working days to submit a revised plan from the date the DEPARTMENT mails, through certified mail, the request for a revised plan. The DEPARTMENT's letter will state the specific revisions to be made in the corrective action plan.

If the CONTRACTOR is unable or unwilling to submit to the DEPARTMENT within the established time frame, a revised corrective action plan containing the

DEPARTMENT's requested revisions, the CONTRACTOR will be subject to the following sanction:

> A $500 penalty for each working day, beginning on the first day after the 20-day time period has expired, and continuing until the day a corrective action plan is submitted to the DEPARTMENT.

4. INITIAL APPEAL OF DEPARTMENT'S FINDINGS

If the CONTRACTOR disagrees with the DEPARTMENT's findings and wishes to appeal those findings, the CONTRACTOR will submit in writing to the DEPARTMENT within the established time frame a detailed explanation of the disagreement. If the DEPARTMENT agrees with the CONTRACTOR, the DEPARTMENT will provide written notification of its decision and will withdraw the request for a corrective action plan.

If the DEPARTMENT upholds its request for a corrective plan, the CONTRACTOR has 20 days from the date the DEPARTMENT mails, through certified mail, a letter upholding its request for a corrective action plan to submit a corrective action plan. If the CONTRACTOR does not submit a corrective action plan within that time frame, the CONTRACTOR will be subject to the following sanction:

> A $500 penalty for each working day, beginning on the first day after the 20-day time period has expired, and continuing until the day a corrective action plan is submitted.

5. FORMAL HEARING

If the DEPARTMENT upholds its decision that a corrective action plan is required, the CONTRACTOR may file a request for a formal hearing with the DEPARTMENT within 30 days from the date the DEPARTMENT mails, through certified mail, a letter upholding its decision. If the $500 penalty has begun, it will discontinue once the DEPARTMENT receives the formal hearing request from the CONTRACTOR.

If the outcome of the formal hearing is in favor of the CONTRACTOR, the DEPARTMENT will provide the CONTRACTOR with written notification that a corrective action plan is no longer required. The DEPARTMENT will reimburse the CONTRACTOR any penalties the CONTRACTOR has paid to the DEPARTMENT that accrued beginning on day 21 from the date the DEPARTMENT mails, through certified mail, the request for a corrective action plan and ending on the day the request for a formal hearing is received by the DEPARTMENT.

If the outcome of the formal hearing is in favor of the DEPARTMENT, the CONTRACTOR will submit a corrective action plan, as determined by the formal hearing decision, within 20 days of the date of the hearing decision, otherwise the CONTRACTOR will be subject to the following sanction:

A $500 penalty for each working day, beginning on the first day after the 20-day time period has expired, and continuing until the day a corrective action plan that complies with the formal hearing decision is submitted to the DEPARTMENT. If the DEPARTMENT determines that the corrective action plan requires revisions, the CONTRACTOR will again be subject to a S500 penalty for each working day beginning on the first day after the DEPARTMENT verbally notifies the CONTRACTOR that the corrective action plan requires revisions and continuing until the day the DEPARTMENT receives the corrective action plan containing the DEPARTMENT's required revisions.

6. CONTRACTOR UNWILLING OR UNABLE TO IMPLEMENT CORRECTIVE ACTION PLAN

If the CONTRACTOR is unwilling or unable to implement the corrective action plan to the satisfaction of the DEPARTMENT, the CONTRACTOR will be subject to the following sanction:

A $500 penalty for each working day, beginning on the first day after the DEPARTMENT verbally notifies the CONTRACTOR that the corrective action plan has not been implemented, and continuing until the day the CONTRACTOR successfully demonstrates to the DEPARTMENT that it has implemented the plan. Following the DEPARTMENT's verbal notification, the DEPARTMENT will mail, through certified mail, a letter stating the penalty has been invoked.

The CONTRACTOR will be apprized of its right to request a formal hearing. If the CONTRACTOR decides to formally appeal the DEPARTMENT's decision that the corrective action plan has not been implemented, then the procedures detailed in number 2 above apply. If the outcome of the formal hearing is in favor of the DEPARTMENT, penalties will resume on the date of the formal hearing decision and continue until the CONTRACTOR complies with the decision of the formal hearing.

7. COLLECTION OF FINANCIAL PENALTIES

The DEPARTMENT may deduct any financial penalties assessed by the DEPARTMENT from the monthly payment to the CONTRACTOR.

F. FEDERAL SANCTIONS FOR COMPREHENSIVE CONTRACTS

Per 42 CFR 434.22, payments made to the CONTRACTOR by the DEPARTMENT under this Contract will be denied for new Enrollees when, and for so long as, payment for those Enrollees are denied by the Health Care Financing Administration for the reasons and the manner specified under 42 CFR 434.67(e).

PROVIDER NAME: ______________________________
SERVICE REPORTING PERIOD: BEGINNING_______________ ENDING ____________
PAYMENT DATES: BEGINNING_______________ ENDING ____________

ATTACHMENT E
TABLE 1 PAGE 1 OF 1
MEDICAID ENROLLMENT

1	2	3	4	5	6	7	8	9	10	11	12	13
LINE NO	MONTH	INFANTS 0-12 MOS	AFDC MALE LESS THAN 21 YEARS GREATER THAN 12 MOS	AFDC MALE 21 + YEARS	AFDC FEMALE LESS THAN 21 YEARS GREATER THAN 12 MOS	AFDC FEMALE 21 + YEARS	AGED	DISABLED MALE	DISABLED FEMALE	MED NEEDY CHILD	MED NEEDY OTHER	NON AFDC PREGNANT FEMALE (SOBRA)
1	JULY											
2	AUGUST											
3	SEPTEMBER											
4	OCTOBER											
5	NOVEMBER											
6	DECEMBER											
7	JANUARY											
8	FEBRUARY											
9	MARCH											
10	APRIL											
11	MAY											
12	JUNE											
13	TOTAL	0	0	0	0	0	0	0	0	0	0	0

1	2	14	15	16
LINE NO	MONTH	RESTRICTION CLIENTS	AIDS	MEDICAID TOTAL (SUM OF COLS 3 THRU 15)
1	JULY			0
2	AUGUST			0
3	SEPTEMBER			0
4	OCTOBER			0
5	NOVEMBER			0
6	DECEMBER			0
7	JANUARY			0
8	FEBRUARY			0
9	MARCH			0
10	APRIL			0
11	MAY			0
12	JUNE			0
13	TOTAL	0	0	0

		MEDICAID (CAPITATED ONLY, NO FEE FOR SERVICE)						
1	2	3	4	5	6	7	8	9
LINE NO	DESCRIPTION	TOTAL UTAH OPERATIONS (INCLUDING ALL MEDICAID)	INFANTS 0-12 MOS	AFDC MALE LESS THAN 21 YEARS GREATER THAN 12 MOS	AFDC MALE 21 + YEARS	AFDC FEMALE LESS THAN 21 YEARS GREATER THAN 12 MOS	AFDC FEMALE 21 + YEARS	AGED
	REVENUES			ROUND TO THE NEAREST DOLLAR				
1	PREMIUMS							
2	DELIVERY FEES (CHILD BIRTH)							
3	REINSURANCE							
4	STOP LOSS							
5	TPL COLLECTIONS - MEDICARE							
6	TPL COLLECTIONS - OTHER							
7	OTHER (SPECIFY)							
8	OTHER (SPECIFY)							
9	TOTAL REVENUES	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0
	MEDICAL COSTS			ROUND TO THE NEAREST DOLLAR				
10	INPATIENT HOSPITAL SERVICES							
11	OUTPATIENT HOSPITAL SERVICES							
12	EMERGENCY DEPARTMENT SERVICES							
13	PRIMARY CARE PHYSICIAN SERVICES							
14	SPECIALTY CARE PHYSICIAN SERVICES							
15	ADULT SCREENING SERVICES							
16	VISION CARE - OPTOMETRIC SERVICES							
17	VISION CARE - OPTICAL SERVICES							
18	LABORATORY (PATHOLOGY) SERVICES							
19	RADIOLOGY SERVICES							
20	PHYSICAL AND OCCUPATIONAL THERAPY							
21	SPEECH AND HEARING SERVICES							
22	PODIATRY SERVICES							
23	END STAGE RENAL DISEASE (ESRD) SERVICES-DIALYSIS							
24	HOME HEALTH SERVICES							
25	HOSPICE SERVICES							
26	PRIVATE DUTY NURSING							
27	MEDICAL SUPPLIES AND MEDICAL EQUIPMENT							
28	ABORTIONS							
29	STERILIZATIONS							
30	DETOXIFICATION							
31	ORGAN TRANSPLANTS							
32	OTHER OUTSIDE MEDICAL SERVICES							
33	LONG TERM CARE							
34	TRANSPORTATION SERVICES							

LINE NO	DESCRIPTION							
35	OTHER (SPECIFY)							
36	TOTAL MEDICAL COSTS	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0

		MEDICAID (CAPITATED ONLY, NO FEE FOR SERVICE)							
		10	11	12	13	14	15	16	17
LINE NO	DESCRIPTION	DISABLED MALE	DISABLED FEMALE	MED NEEDY CHILD	MED NEEDY OTHER	NON AFDC PREGNANT FEMALE (SOBRA)	RESTRICTION CLIENTS	AIDS	MEDICAID TOTAL (SUM OF COLS 4 THRU 16)
	REVENUES	ROUND TO THE NEAREST DOLLAR							
1	PREMIUMS								$ 0
2	DELIVERY FEES (CHILD BIRTH)								$ 0
3	REINSURANCE								$ 0
4	STOP LOSS								$ 0
5	TPL COLLECTIONS - MEDICARE								$ 0
6	TPL COLLECTIONS - OTHER								$ 0
7	OTHER (SPECIFY)								$ 0
8	OTHER (SPECIFY)								$ 0
9	TOTAL REVENUES	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0
	MEDICAL COSTS	ROUND TO THE NEAREST DOLLAR							
10	INPATIENT HOSPITAL SERVICES								$ 0
11	OUTPATIENT HOSPITAL SERVICES								$ 0
12	EMERGENCY DEPARTMENT SERVICES								$ 0
13	PRIMARY CARE PHYSICIAN SERVICES								$ 0
14	SPECIALTY CARE PHYSICIAN SERVICES								$ 0
15	ADULT SCREENING SERVICES								$ 0
16	VISION CARE - OPTOMETRIC SERVICES								$ 0
17	VISION CARE - OPTICAL SERVICES								$ 0
18	LABORATORY (PATHOLOGY) SERVICES								$ 0
19	RADIOLOGY SERVICES								$ 0
20	PHYSICAL AND OCCUPATIONAL THERAPY								$ 0
21	SPEECH AND HEARING SERVICES								$ 0
22	PODIATRY SERVICES								$ 0
23	END STAGE RENAL DISEASE (ESRD) SERVICES-DIALYSIS								$ 0
24	HOME HEALTH SERVICES								$ 0
25	HOSPICE SERVICES								$ 0
26	PRIVATE DUTY NURSING								$ 0
27	MEDICAL SUPPLIES AND MEDICAL EQUIPMENT								$ 0
28	ABORTIONS								$ 0
29	STERILIZATIONS								$ 0
30	DETOXIFICATION								$ 0
31	ORGAN TRANSPLANTS								$ 0
32	OTHER OUTSIDE MEDICAL SERVICES								$ 0
33	LONG TERM CARE								$ 0
34	TRANSPORTATION SERVICES								$ 0
35	OTHER (SPECIFY)								$ 0
36	TOTAL MEDICAL COSTS	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0

		MEDICAID (CAPITATED ONLY, NO FEE FOR SERVICE)						
1	2	3	4	5	6	7	8	9
LINE NO	DESCRIPTION	TOTAL UTAH OPERATIONS (INCLUDING ALL MEDICAID)	INFANTS 0-12 MOS	AFDC MALE LESS THAN 21 YEARS GREATER THAN 12 MOS	AFDC MALE 21 + YEARS	AFDC FEMALE LESS THAN 21 YEARS GREATER THAN 12 MOS	AFDC FEMALE 21 + YEARS	AGED
	ADMINISTRATIVE COSTS			ROUND TO THE NEAREST DOLLAR				
37	ADMINISTRATION - ADVERTISING							
38	HOME OFFICE INDIRECT COST ALLOCATIONS							
39	UTILIZATION							
40	ADMINISTRATION - OTHER							
41	TOTAL ADMINISTRATIVE COSTS	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0
42	TOTAL COSTS (MED & ADMIN)	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0
43	NET INCOME [Gain or (Loss)]	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0
44	ENROLLEE MONTHS		0	0	0	0	0	0
45	MEDICAL COST @ ENROLLEE MO							
0								
46	ADMIN COST @ ENROLLEE MO							
47	TOTAL COST @ ENROLLEE MO							
	OTHER DATA							
48	TPL SAVINGS - COST AVOIDANCE **							
49	DUPLICATE PREMIUMS ***							
50	NUMBER OF DELIVERIES ****							
51	FAMILY PLANNING SERVICES							
52	REINSURANCE PREMIUMS RECEIVED							
53	REINSURANCE PREMIUMS PAID							
54	ADMINISTRATIVE REVENUE RETAINED BY THE CONTRACTOR							

		MEDICAID (CAPITATED ONLY, NO FEE FOR SERVICE)							
		10	11	12	13	14	15	16	17
LINE NO	DESCRIPTION	DISABLED MALE	DISABLED FEMALE	MED NEEDY CHILD	MED NEEDY OTHER	NON AFDC PREGNANT FEMALE (SOBRA)	RESTRICTION CLIENTS	AIDS	MEDICAID TOTAL (SUM OF COLS 4 THRU 16)
	ADMINISTRATIVE COSTS					ROUND TO THE NEAREST DOLLAR			
37	ADMINISTRATION - ADVERTISING								$ 0
38	HOME OFFICE INDIRECT COST ALLOCATIONS								$ 0
39	UTILIZATION								$ 0
40	ADMINISTRATION - OTHER								$ 0
41	TOTAL ADMINISTRATIVE COSTS	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0
42	TOTAL COSTS (MED & ADMIN)	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0
43	NET INCOME [Gain or (Loss)]	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0

44	ENROLLEE MONTHS	0	0	0	0	0	0	0	0
45	MEDICAL COST @ ENROLLEE MO								
46	ADMIN COST @ ENROLLEE MO								
47	TOTAL COST @ ENROLLEE MO								
	OTHER DATA								
48	TPL SAVINGS - COST AVOIDANCE **								$ 0
49	DUPLICATE PREMIUMS ***								$ 0
50	NUMBER OF DELIVERIES ****								0
51	FAMILY PLANNING SERVICES								$ 0
52	REINSURANCE PREMIUMS RECEIVED								$ 0
53	REINSURANCE PREMIUMS PAID								$ 0
54	ADMINISTRATIVE REVENUE RETAINED BY THE CONTRACTOR								$ 0

** COST OF SERVICES PROVIDED TO HMO CLIENTS, NOT PAID FOR BY HMO, E.G."AVOIDED", BECAUSE OTHER INSURANCE PAID FOR IT.
*** CASH AMOUNT RETURNED TO MEDICAID BY HMO BECAUSE HMO CLIENT WAS COVERED IN THE SAME HMO BY ANOTHER CARRIER.
**** NUMBER OF CHILDREN DELIVERED. THIS NUMBER TIMES RATES SHOULD EQUAL DELIVERY REVENUE.

In this Medicaid portion, include only costs for Medicaid clients under the capitation agreement - exclude revenue, costs & TPL categories per this form that do not apply to your organization or contract.

MEDICAL SERVICES REVENUE AND COST DEFINITIONS FOR TABLE 2

REVENUES (Report all revenues received or receivable at the end-of-period date on the form)

1. Premiums

   Report premium payments received or receivable from the DEPARTMENT.

2. Delivery Fees

   Report the delivery fee received or receivable from the DEPARTMENT.

3. Reinsurance

   Report the reinsurance payments received or receivable from the REINSURANCE CARRIER (See Attachment F, Section D, Items 1 and 2).

4. Stop Loss

   Report stop loss payments received or receivable from the DEPARTMENT (See Attachment F, Section D, Item 2).

5. TPL Collections - Medicare

   Report all third party collections received from Medicare.

6. TPL Collections - Other

   Report all third party collections received other than Medicare collections. (Report TPL savings because of cost avoidance as a memo amount on line 48).

7. Other (specify)

8. Other (specify)

   For lines seven and eight: Report all other revenue not included in lines one through six. (There may not be any amount to report; however, this line can be used to report revenue from total Utah operations that do not fit lines one through six.)

9. TOTAL REVENUES

   Total lines one through eight.

NOTE: Duplicate premiums are not considered a cost or revenue as they are collected by the CONTRACTOR and paid to the DEPARTMENT. Therefore, the payment to the DEPARTMENT would reduce or offset the revenue recorded when the duplicate premium was received. However, line 49 has been established for reporting duplicate premiums as a memo amount.

MEDICAL COSTS: Report all costs accrued as of the ending date on the form. In the first data column (column 3), report all costs for Utah operations per the general ledger. In the 14 Medicaid data columns (columns 4 through 17), report only costs for Medicaid Enrollees.

10. Inpatient Hospital Services

Costs incurred in providing inpatient hospital services to Enrollees confined to a hospital.

11. Outpatient Hospital Services

Costs incurred in providing outpatient hospital services to Enrollees, not including services provided in the emergency department.

12. Emergency Department Services

Costs incurred in providing outpatient hospital emergency room services to Enrollees.

13. Primary Care Physician Services (Including EPSDT Services, Prenatal Care, and Family Planning Services)

All costs incurred for Enrollees as a result of providing primary care physician, osteopath, physician assistant, nurse practitioner, and nurse midwife services, including payroll expenses, any capitation and/or contract payments, fee-for-service payments, fringe benefits, travel and office supplies.

14. Specialty Care Physician Services (Including EPSDT Services, Prenatal Care, and Family Planning Services)

All costs incurred as a result of providing specialty care physician, osteopath, physician assistant, nurse practitioner, and nurse midwife services to Enrollees, including payroll expenses, any capitation and/or contract payments, fee-for-service payments, fringe benefits, travel and office supplies.

15. Adult Screening Services

Expenses associated with providing screening services to Enrollees.

16. Vision Care - Optometric Services

Included are payroll costs, any capitation and/or contract payments, and fee-for-service payments for services and procedures performed by an optometrist and other non-payroll expenses directly related to providing optometric services for Enrollees.

17. Vision Care - Optical Services

Included are payroll costs, any capitation and/or contract payments and fee-for-service payments for services and procedures performed by an optician and other supportive staff, cost of eyeglass frames and lenses and other non-payroll expenses directly related to providing optical services for Enrollees.

18. Laboratory (Pathology) Services

Costs incurred as a result of providing pathological tests or services to Enrollees including payroll expenses, any capitation and/or contract payments, fee-for-service payments and other expenses directly related to in-house laboratory services. Excluded are costs associated with a hospital visit.

19. Radiology Services

Cost incurred in providing x-ray services to Enrollees, including x-ray payroll expenses, any capitation and/or contract payments, fee-for-service payments, and occupancy overhead costs. Excluded are costs associated with a hospital visit.

20. Physical and Occupational Therapy

Included are payroll costs, any capitation and/or contract payments, fee-for-service costs, and other non-payroll expenditures directly related to providing physical and occupational therapy services.

21. Speech and Hearing Services

Payroll costs, any capitation and/or contract payments, fee-for-service payments, and non-payroll costs directly related to providing speech and hearing services for Enrollees.

22. Podiatry Services

Salary expenses or outside claims, capitation and/or contract payments, fee-for-service payments, and non-payroll costs directly related to providing services rendered by a podiatrist to Enrollees.

23. End Stage Renal Disease (ESRD) Services - Dialysis

Costs incurred in providing renal dialysis (ESRD) services to Enrollees.

24. Home Health Services

Included are payroll costs, any capitation and/or contract payments, fee-for-service payments, and other non-payroll expenses directly related to providing home health services for Enrollees.

25. Hospice Services

Expenses related to hospice care for Enrollees including home care, general inpatient care for Enrollees suffering terminal illness and inpatient respite care for caregivers of Enrollees suffering terminal illness.

26. Private Duty Nursing

Expenses associated with private duty nursing for Enrollees.

27. Medical Supplies and Medical Equipment

This cost center contains fee-for-service cost for outside acquisition of medical requisites, special appliances as prescribed by the CONTRACTOR to Enrollees.

28. Abortions

Medical and hospital costs incurred in providing abortions for Enrollees.

29. Sterilizations

Medical and hospital costs incurred in providing sterilizations for Enrollees.

30. Detoxification

Medical and hospital costs incurred in providing treatment for substance abuse and dependency (detoxification) for Enrollees.

31. Organ Transplants

Medical and hospital costs incurred in providing transplants for Enrollees.

32. Other Outside Medical Services

The costs for specialized testing and outpatient surgical centers for Enrollees ordered by the CONTRACTOR.

33. Long Term Care

Costs incurred in providing long-term care for Enrollees required under Attachment C.

34. Transportation Services

Costs incurred in providing ambulance (ground and air) services for Enrollees.

35. Other

Report costs not otherwise reported.

36. TOTAL MEDICAL COSTS

Total lines 10 through 35.

ADMINISTRATIVE COSTS

Report payroll costs, any capitation and/or contract payments, non-payroll costs and occupancy overhead costs for accounting services, claims processing services, health plan services, data processing services, purchasing, personnel, Medicaid marketing and regional administration.

Report the administration cost under four categories - advertising, home office indirect cost allocation, utilization and all other administrative costs. If there are no advertising costs or indirect home office cost allocations, report a zero amount in the applicable lines.

37. Administration - Advertising

38. Home Office Indirect Cost Allocations

39. Utilization

    Payroll cost and any capitation and/or contract payments for utilization staff and other non-payroll costs directly associated with controlling and monitoring outside physician referral and hospital admission and discharges of Enrollees.

40. Administration - Other

41. TOTAL ADMINISTRATIVE COSTS

    Total lines 37 through 40.

42. TOTAL COSTS (Medical and Administrative)

    Total lines 36 and 41.

43. NET INCOME (Gain or Loss)

    Line 9 minus line 42.

44. ENROLLEE MONTHS

    Total Enrollee months for period of time being reported.

45. MEDICAL COSTS PER ENROLLEE MONTH

    Line 36 divided by line 44.

46. ADMINISTRATIVE COSTS PER ENROLLEE MONTH

    Line 41 divided by line 44.

47. TOTAL COSTS PER ENROLLEE MONTH

    Line 42 divided by line 44.

OTHER DATA

48. TPL Savings - Cost Avoidance

49. Duplicate Premiums

Include all premiums received for Enrollees from all sources other than Medicaid.

50. Number of Deliveries

Total number of Enrollee deliveries when the delivery occurred at 24 weeks or later.

51. Family Planning Services

Include costs associated with family planning services as defined in Attachment C (Covered Services, Section V, Family Planning Services).

52. Reinsurance Premiums Received

Include the reinsurance premiums received or receivable from the DEPARTMENT.

53. Reinsurance Premiums Paid.

Include reinsurance premiums paid to the REINSURANCE CARRIER.

54. Administrative Revenue Retained by the CONTRACTOR

Include the administrative revenue retained by the CONTRACTOR from the reinsurance premiums received or receivable from the DEPARTMENT.

MEDICAID (CAPITATED ONLY, NO FEE FOR SERVICE)

1	2	3	4	5	6	7	8
LINE NO	SERVICE DESCRIPTION (REFER TO THE UNIT OF SERVICE) DEFINITIONS IN THE INSTRUCTIONS)	INFANTS 0-12 MOS	AFDC MALE LESS THAN 21 YEARS GREATER THAN 12 MOS	AFDC MALE 21 + YEARS	AFDC FEMALE LESS THAN 21 YEARS GREATER THAN 12 MOS	AFDC FEMALE 21 + YEARS	AGED
1	HOSPITAL SERVICES - GENERAL DAYS						
2	HOSPITAL SERVICES - DISCHARGES						
3	HOSPITAL SERVICES - OUTPATIENT VISITS						
4	EMERGENCY DEPARTMENT VISITS						
5	PRIMARY CARE PHYSICIAN SERVICES						
6	SPECIALTY CARE PHYSICIAN SERVICES						
7	ADULT SCREENING SERVICES						
8	VISION CARE - OPTOMETRIC SERVICES						
9	VISION CARE - OPTICAL SERVICES						
10	LABORATORY (PATHOLOGY) PROCEDURES						
11	RADIOLOGY PROCEDURES						
12	PHYSICAL AND OCCUPATIONAL THERAPY SERVICES						
13	SPEECH AND HEARING SERVICES						
14	PODIATRY SERVICES						
15	END STAGE RENAL DISEASE (ESRD) SERVICES - DIALYSIS						
16	HOME HEALTH SERVICES						
17	HOSPICE DAYS						
18	PRIVATE DUTY NURSING SERVICES						
19	MEDICAL SUPPLIES AND MEDICAL EQUIPMENT						
20	ABORTIONS PROCEDURES						
21	STERILIZATION PROCEDURES						
22	DETOXIFICATION DAYS						
23	ORGAN TRANSPLANTS						
24	OTHER OUTSIDE MEDICAL SERVICES						
25	LONG TERM CARE FACILITY DAYS						
26	TRANSPORTATION TRIPS						
27	OTHER (SPECIFY)						

MEDICAID (CAPITATED ONLY, NO FEE FOR SERVICE)

1	2	9	10	11	12	13	14	15	16
LINE NO	SERVICE DESCRIPTION (REFER TO THE UNIT OF SERVICE) DEFINITIONS IN THE INSTRUCTIONS)	DISABLED MALE	DISABLED FEMALE	MED NEEDY CHILD	MED NEEDY OTHER	NON AFDC PREGNANT FEMALE (SOBRA)	RESTRICTION CLIENTS RESTRICTION CLIENTS	AIDS	MEDICAID TOTAL (SUM OF COLS 3 THRU 15)
1	HOSPITAL SERVICES - GENERAL DAYS								0
2	HOSPITAL SERVICES - DISCHARGES								0
3	HOSPITAL SERVICES - OUTPATIENT VISITS								0
4	EMERGENCY DEPARTMENT VISITS								0
5	PRIMARY CARE PHYSICIAN SERVICES								0

6	SPECIALTY CARE PHYSICIAN SERVICES	0
7	ADULT SCREENING SERVICES	0
8	VISION CARE - OPTOMETRIC SERVICES	0
9	VISION CARE - OPTICAL SERVICES	0
10	LABORATORY (PATHOLOGY) PROCEDURES	0
11	RADIOLOGY PROCEDURES	0
12	PHYSICAL AND OCCUPATIONAL THERAPY SERVICES	0
13	SPEECH AND HEARING SERVICES	0
14	PODIATRY SERVICES	0
15	END STAGE RENAL DISEASE (ESRD) SERVICES - DIALYSIS	0
16	HOME HEALTH SERVICES	0
17	HOSPICE DAYS	0
18	PRIVATE DUTY NURSING SERVICES	0
19	MEDICAL SUPPLIES AND MEDICAL EQUIPMENT	0
20	ABORTIONS PROCEDURES	0
21	STERILIZATION PROCEDURES	0
22	DETOXIFICATION DAYS	0
23	ORGAN TRANSPLANTS	0
24	OTHER OUTSIDE MEDICAL SERVICES	0
25	LONG TERM CARE FACILITY DAYS	0
26	TRANSPORTATION TRIPS	0
27	OTHER (SPECIFY)	0

NOTE: MEDICAL REQUISITIONS HAS BEEN DITCHED!!

MEDICAL SERVICES UTILIZATION DEFINITIONS FOR TABLE 3

MEDICAL SERVICES

1. Hospital Services - General Days

   Record total number of inpatient hospital days associated with inpatient medical care.

2. Hospital Services - Discharges

   Record total number of inpatient hospital discharges.

3. Hospital Services - Outpatient Visits

   Record total number of outpatient visits.

4. Emergency Department Visits

   Record total number of emergency room visits

5. Primary Care Physician Services

   Number of services and procedures defined by CPT-4 codes provided by primary care physicians or licensed physician extenders or assistants under direct supervision of a physician inclusive of all services except radiology, laboratory and injections/immunizations which should be reported in their appropriate section. The reporting of data under this category includes both outpatient and inpatient services.

6. Specialty Care Physician Services

   Number of services and procedures defined by CPT-4 codes provided by specialty care physicians or licensed physician extenders or assistants under direct supervision of a physician inclusive of all services except radiology, laboratory and injections/immunizations which should be reported in their appropriate section. The reporting of data under this category includes both outpatient and inpatient services.

7. Adult Screening Services

   Number of adult screenings performed.

8. Vision Care - Optometric Services

   Number of optometric services and procedures performed by an optometrist.

9. Vision Care - Optical Services

   Number of eye glasses and contact lenses dispensed.

10. Laboratory (Pathology) Procedures

Number of procedures defined by CPT-4 Codes under the Pathology and Laboratory section. Excluded are services performed in conjunction with a hospital outpatient or emergency department visit.

11. Radiology Procedures

Number of procedures defined by CPT-4 Codes under the Radiology section. Excluded are services performed in conjunction with a hospital outpatient or emergency department visit.

12. Physical and Occupational Therapy Services

Physical therapy refers to physical and occupational therapy services and procedures performed by a physician or physical therapist.

13. Speech and Hearing Services

Number of services and procedures.

14. Podiatry Services

Number of services and procedures.

15. End Stage Renal Disease (ESRD) Services - Dialysis

Number of ESRD procedures provided upon referral.

16. Home Health Services

Number of home health visits, such as skilled nursing, home health aide, and personal care aide visits.

17. Hospice Days

Number of days hospice care is provided, including respite care.

18. Private Duty Nursing Services

Hours of skilled care delivered.

19. Medical Supplies and Medical Equipment

Durable medical equipment such as wheelchairs, hearing aids, etc., and nondurable supplies such as oxygen etc.

20. Abortion Procedures

Number of procedures performed.

21. Sterilization Procedures

    Number of procedures performed.

22. Detoxification Days

    Days of inpatient detoxification.

23. Organ Transplants

    Number of transplants.

24. Other Outside Medical Services

    Specialized testing and outpatient surgical services ordered by IHC.

25. Long Term Care Facility Days

    Total days associated with long-term care.

26. Transportation Trips

    Number of ambulance trips.

27. Other (specify)

ATTACHMENT E
TABLE 4 PAGE 1 OF 1
MEDICAID MALPRACTICE INFORMATION

PROVIDER NAME: ____

SERVICE REPORTING PERIOD: BEGINNING ___________ ENDING ____________

ORGANIZATIONS NAMED IN THE MALPRACTICE CLAIM:

CLAIM NUMBER 1 ____

CLAIM NUMBER 2 ____

CLAIM NUMBER 3 ____

MEDICAL PROFESSIONALS SPECIFIED:

CLAIM NUMBER 1 ____

CLAIM NUMBER 2 ____

CLAIM NUMBER 3 ____

LOCATIONS WHERE CLAIMS ORIGINATED:

CLAIM NUMBER 1 ____

CLAIM NUMBER 2 ____

CLAIM NUMBER 3 ____

MEDICAID CLIENT IDENTIFICATION:

CLAIM NUMBER 1 ____

CLAIM NUMBER 2 ____

CLAIM NUMBER 3 ____

DATES OF SERVICE:

CLAIM NUMBER 1 ____

CLAIM NUMBER 2 ____

CLAIM NUMBER 3 ____

AWARDS TO MEDICAID CLIENTS - AMOUNTS & DATES PAID

CLAIM NUMBER 1 ____

CLAIM NUMBER 2 ____

CLAIM NUMBER 3 ____

HMO'S DIRECT COSTS (IF ANY)

CLAIM NUMBER 1 ____

CLAIM NUMBER 2 ____

CLAIM NUMBER 3 ____

ATTACH A SUMMARY OF FACTS FOR EACH CASE, DESCRIBING THE CLAIM, THE CAUSES, CIRCUMSTANCES, ETC.

The information reported on this form should come from known malpractice cases of the MCO providers. This may only be applicable if the MCO was named as a participant in the malpractice suit. However, if suits against MCO providers are known, provide us with information on the Medicaid client(s) involved and any large settlements paid when the information is available.

ATTACHMENT F - RATES AND RATE-RELATED TERMS

Effective July 1, 1999

AMERICAN FAMILY CARE

A. PREMIUM RATES

1. MONTHLY PREMIUM RATES BASED ON ENROLLEES' RATE CELLS

Age 0 to1	TANF Male 1 to 21	TANF Male 21 & Over	TANF Female 1 to 21	TANF Female 21 & Over	Aged
$ [*]	$ [*]	$ [*]	$ [*]	$ [*]	$ [*]

Disabled Male	Disabled Female	Medically Needy Child	Medically Needy Adult	Non TANF Pregnant F	Restriction Program
$ [*]	$ [*]	$ [*]	$ [*]	$ [*]	$ [*]

2. SPECIAL RATE

An AIDS rate of $[*] per month will be paid in addition to the regular monthly premium when the T-Cell count is below 200.

B. PER DELIVERY REIMBURSEMENT SCHEDULE

The DEPARTMENT shall reimburse the CONTRACTOR $[*] per delivery to cover all Medically Necessary antepartum care, delivery, and postpartum professional, facility and ancillary services. The monthly premium amount for the enrollee is in addition to the delivery fee. The delivery payment will be made when the delivery occurs at 22 weeks or later, regardless of viability.

C. CHEC SCREENING INCENTIVE CLAUSE

1. CHEC SCREENING GOAL

The CONTRACTOR will ensure that Medicaid children have access to appropriate well-child visits. The CONTRACTOR will follow the Utah EPSDT (CHEC) guidelines for the periodicity schedule for well-child protocol. The federal agency, Health Care Financing Administration, mandates that all states have 80% of all children screened. The DEPARTMENT and the CONTRACTOR will work toward that goal.

2. CALCULATION OF CHEC INCENTIVE PAYMENT

The DEPARTMENT will pay the CONTRACTOR $[*] for each percentage point over 60% achieved by the CONTRACTOR. The DEPARTMENT will calculate the CONTRACTOR's annual participation rate based on information supplied by the CONTRACTOR under the EPSDT (CHEC) reporting requirements at the same time each federal fiscal year's HCFA-416 is calculated. Payment will be based on the percentages determined at that time.

3. CONTRACTOR'S USE OF INCENTIVE PAYMENT

The CONTRACTOR agrees to use this incentive payment to reward the CONTRACTOR's employees responsible for improving the EPSDT (CHEC) participation rate.

D. STOP-LOSS/REINSURANCE POLICY

Stop-loss under item #1 below will be administered by a reinsurer, TransAmerica Occidental Life Insurance Company (TransAmerica). TransAmerica will partially administer stop-loss under item #2 below.

1. REINSURANCE (all services including kidney, liver, and cornea and excluding specific organ transplantations defined in D.2. below)

Costs, net of TPL, for all inpatient and outpatient services listed in Attachment C (including kidney, liver, and cornea transplantations, but excluding bone marrow, heart, intestine, lung, pancreas, small bowel, combination heart/lung, combination intestine/liver, combination kidney/pancreas, multi visceral, combination liver/small bowel, any additional approved transplantations) that are covered on the date of service rendered and incurred from July 1, 1999 through June 30, 2000 by the MCO for an Enrollee shall be shared by Transamerica under the following conditions:

a. the date of service is from July 1, 1999 through June 30, 2000 (based on date of discharge if inpatient hospital stay);

b. paid claims incurred by the MCO exceed $50,000; and

c. services shall have been incurred by the MCO during the time the client is enrolled with the MCO.

If the above conditions are met, TransAmerica shall bear [*]% and the MCO shall bear [*]% of the amount that exceeds $50,000.

2. STOP-LOSS/REINSURANCE FOR SPECIFIC ORGAN TRANSPLANTATIONS

Costs, net of TPL, for bone marrow, heart, intestine, lung, pancreas, small bowel, combination heart/lung, combination intestine/liver, combination kidney/pancreas, multi visceral, combination liver/small bowel, and any additional approved transplantations (other than kidney, liver, and cornea) that are covered on the date of service rendered and incurred from July 1, 1999 through June 30, 2000 by the

MCO for an Enrollee shall be shared by the DEPARTMENT, Transamerica and the MCO under the following conditions:

a. the date of service is from July 1, 1999 through June 30, 2000 (based on date of discharge if inpatient hospital stay);

b. paid claims incurred by the MCO exceed $40,000; and

c. services shall have been incurred by the MCO during the time the client is enrolled with the MCO;

d. the stop-loss billings for the first $40,000 must be submitted to the DEPARTMENT in a format mutually agreed upon; and

e. stop-loss billings for the first $40,000 must be submitted to the DEPARTMENT within six months of the end of the Contract year.

If the above conditions are met, the DEPARTMENT shall reimburse the MCO the first $40,000; TransAmerica, shall bear [*]% and the MCO shall bear [*]% of the amount that exceeds $40,000.

Stop-loss/reinsurance provisions are normally based on services provided within the contract period ending June 30. However, for purposes of this stop-loss/ reinsurance provision the Contract period is extended for transplantations performed between April 1, 2000 and June 30, 2000. When the transplantation is performed between April 1, 2000 and June 30, 2000 the payment for the first $40,000 of the transplantation costs and the costs that exceed $40,000 can be applied to this stop-loss/reinsurance provision for up to 90 days after the transplantation is performed.

E. REIMBURSEMENT FOR REINSURANCE

The CONTRACTOR agrees to purchase reinsurance from TransAmerica at the rate negotiated by the DEPARTMENT of $[*] per Enrollee per month. The DEPARTMENT will reimburse the CONTRACTOR for their premium payments to TransAmerica. In addition, the DEPARTMENT will pay the CONTRACTOR [*]% of the premium to cover reinsurance administrative costs.

1. INTERIM PAYMENTS

Beginning July 1, 1999, the DEPARTMENT will make monthly interim payments to the CONTRACTOR based on the reinsurance premiums the CONTRACTOR pays to Insurance Strategies, an agent of TransAmerica. The reinsurance premiums will be calculated using the previous month's number of Enrollees.

2. FINAL SETTLEMENT

The DEPARTMENT will calculate the actual reinsurance amount due to the CONTRACTOR one month after the end of each contract year. The settlement will be based on actual Enrollee months.

ATTACHMENT G

UTAH MCO QUALITY ASSURANCE MONITORING PLAN

[SEAL]

Utah State Department of Health
Division of Health Care Financing
Bureau of Managed Health Care
July 1, 1999

UTAH MCO QUALITY ASSURANCE MONITORING PLAN
BUREAU OF MANAGED HEALTH CARE
UTAH DIVISION OF HEALTH CARE FINANCING

AUTHORITY

The authority for the evaluation of care provided to Medicaid clients by the Managed Care Organizations (MCOs) contracting with the State is found in CFR 417; and 443 Subpart C, D, and E.

PURPOSE

The purpose of the Utah MCO Quality Assurance Monitoring Plan is to assure quality care is received by the Medicaid client in a cost-effective manner and to monitor that problems identified are addressed to continually improve the quality of services delivered.

METHOD OF REVIEW

A. Accreditation by a nationally recognized accreditation agency that is also recognized by the State will be accepted to fulfill some standards and requirements. The MCO will have to show proof of accreditation in that area.

B. State staff and/or an external quality review organization (EQRO) or a combination of the two will monitor other standards and requirements. This will be done by an on-site review or by documentation submitted by the MCO.

DEFINITIONS AND ABBREVIATIONS

A. Division of Health Care Financing (DHCF)

B. External Quality Review Organization (EQRO)

C. Health Maintenance Organization (HMO) - means a public or private organization operating under State law that is federally qualified or meets the State Plan's definition of an HMO. The HMO operates under a prepaid arrangement to provide specified services to a specific group of clients.

D. Managed Care Organization (MCO) - means an organization that meets the State Plan's definition of an HMO or the State Plan's definition of a prepaid health plan and which provides, either directly or through arrangements with other providers, comprehensive general medical services to Medicaid eligibles on a contractual prepayment basis.

E. Quality Assurance Plan (QAP)

F. State Medicaid Agency - means Division of Health Care Financing (DHCF)

QUALITY ASSURANCE STANDARDS

All MCOs contracting with the Utah Division of Health Care Financing will be monitored for compliance of the following standards.

Standards I through IX, XV and XVI should be addressed in the MCO's Quality Assurance Plan (QAP). The QAP should also address confidentiality of the information gathered during quality assurance activities.

STANDARD I: WRITTEN QUALITY ASSURANCE PLAN DESCRIPTION. The organization must have a written description of its QAP. The written description must meet the following criteria.

A. Goals and Objectives - The written description contains a detailed set of quality assurance objectives which are developed annually and include a timetable for implementation and accomplishment.

B. Scope:

1. The scope of the QAP is comprehensive, addressing both the quality of clinical care and the quality of non-clinical aspects of service, such as and including: availability, accessibility, coordination, and continuity of care.

2. The QAP methodology provides for review of the entire range of care provided by the organization, by assuring that all demographic groups, care settings (e.g. inpatient, ambulatory [including care provided in private practice offices], and home care), and types of services (e.g., preventative, primary, specialty care, and ancillary) are included in the scope of the review.

   This review of the entire range of care is expected to be carried out over multiple review periods and not on a concurrent basis.

C. Specific Activities: - The written description specifies quality of care studies and other activities to be undertaken over a prescribed period of time, and methodologies and organizational arrangements to be used to accomplish them. Individuals responsible for the studies and other activities are clearly identified and are appropriate.

D. Continuous Activity - The written description provides for continuous performance of the activities, including tracking of issues over time.

E. Provider Review - The QAP provides for:

1. Review by physicians and other health professionals of the process followed in the provision of health services; and

2. Feedback to health professionals and MCO staff regarding performance and patient results.

F. Focus on health outcomes - The QAP methodology addresses health outcomes to the extent consistent with existing technology.

STANDARD II: SYSTEMATIC PROCESS OF QUALITY ASSESSMENT AND IMPROVEMENT. The QAP objectively and systematically monitors and evaluates the quality and appropriateness of care and service to members, through quality of care studies and related activities, and pursues opportunities for improvement on an ongoing basis. The QAP has written guidelines for its quality of care studies and related activities which include:

A. Specification of clinical or health services delivery areas to be monitored.

1. The monitoring and evaluation of care reflects the population served by the MCO in terms of age groups, disease categories, and special risk status.

2. For the Medicaid population, the QAP monitors and evaluates, at a minimum, care and services in certain priority areas of concern selected by the State. This would include studies specified in the Medicaid contract with each individual MCO.

B. Use of Quality Indicators - Quality indicators are measurable variables relating to a specified clinical or health services delivery area, which are reviewed over a period of time to monitor the process of care delivered in that area.

1. The organization identifies and uses quality indicators that are objective, measurable, and based on current knowledge and clinical experience.

2. For the priority areas selected by the State from the HCFA Medicaid Bureau's list of priority clinical and health services delivery areas of concern, the organization monitors and evaluates quality of care through studies which include, but are not limited to those specified in Attachment A.

3. Methods and frequency of data collection are appropriate and sufficient to detect need for program change.

C. Use of clinical care standards\practice guidelines.

1. The studies or other activities of the QAP specify the health service delivery standards or practice guidelines used to monitor the quality of care for each area identified in Standard II A.

2. The standards/guidelines are based on reasonable scientific evidence and are developed or reviewed by plan providers.

3. The standards/guidelines focus on the process and outcomes of health care delivery, as well as access to care.

4. A mechanism is in place for continuously updating the standard/guidelines.

5. The standards/guidelines shall be disseminated to providers as they are adopted.

6. The standards/guidelines address preventive health services.

7. Standards/guidelines are developed for the full spectrum of populations enrolled in the plan.

8. The QAP shall use these standards/guidelines to evaluate the quality of care provided by the MCO's providers.

D. Analysis of clinical care and related services.

1. Appropriate clinicians monitor and evaluate quality through review of individual cases where there are questions about care, and through studies analyzing patterns of clinical care and related service. For quality issues identified in the QAP's targeted clinical areas, the analysis includes the identified quality indicators and uses clinical care standards or practice guidelines.

2. Multidisciplinary teams are used, where indicated, to analyze and address systems issues.

3. From 1 and 2, clinical and related service areas requiring improvement are identified.

E. Implementation of remedial/corrective actions.

The QAP includes written procedures for taking appropriate remedial action whenever services are furnished, or services that should have been furnished were not, as determined under the QAP as inappropriate or substandard. These written remedial/corrective action procedures include:

1. specification of the types of problems requiring remedial/corrective action;

2. specification of the person(s) or body responsible for making the final determinations regarding quality problems;

3. specific actions to be taken;

4. provision of feedback to appropriate health professionals, providers and staff;

5. the schedule and accountability for implementing corrective actions;

6. the approach to modifying the corrective action if improvements do not occur; and

7. procedures for terminating the affiliation with the physician, or other health professional or provider.

F. Assess effectiveness of corrective actions.

1. As actions are taken to improve care, there is monitoring and evaluation of corrective actions to assure that appropriate changes have been made. In addition, changes in practice patterns are tracked.

2. The MCO assures follow-up on identified issues to ensure that actions for improvement have been effective.

G. Evaluation of continuity and effectiveness of the QAP.

1. The MCO conducts a regular and periodic examination of the scope and content of the QAP to ensure it covers all types of services in all settings, as specified in STANDARD I-B-2.

2. At the end of each year, a written report on the QAP is prepared, which addresses: Quality assurance studies and other activities completed; trending of clinical and services indicators and other performance data; demonstrated improvements in quality; areas of deficiency and recommendations for corrective action, and an evaluation of the overall effectiveness of the QAP.

3. There is evidence that quality assurance activities have contributed to significant improvements in the care delivered to members.

STANDARD III: ACCOUNTABILITY TO THE GOVERNING BODY. The governing body of the organization is the Board of Directors or, where the Board's participation with quality improvement issues is not direct, a designated committee of the senior management of the MCO. Responsibilities of the Governing Body for monitoring, evaluation, and making improvements to care includes:

A. Oversight of QAP - there is documentation that the Governing Body has approved the overall QAP and an annual QAP.

B. Oversight - The Governing Body has formally designated an accountable entity or entities within the organization to provide oversight for quality assurance activities or has formally decided to provide such oversight as a committee of the whole.

C. QAP progress reports - The Governing Body routinely receives written reports from the QAP describing actions taken, progress in meeting quality assurance objectives, and improvements made.

D. Annual QAP review - The Governing Body formally reviews on a periodic basis (but no less frequently than annually) a written report on the QAP that includes: studies undertaken, results, subsequent actions, and aggregate data on utilization and quality of services rendered to assess the QAP's continuity, effectiveness and current acceptability.

E. Program modification - Upon receipt of regular written reports from the QAP delineating actions taken and improvements made, the Governing Body takes action when appropriate and directs that the operational QAP be modified on an ongoing basis to accommodate review findings and issues of concern within the MCO. This activity is documented in the minutes of the meetings of the Governing Board in sufficient detail to demonstrate that it has directed and followed up on necessary actions pertaining to quality assurance.

STANDARD IV: ACTIVE QUALITY ASSURANCE COMMITTEE. The QAP delineates an identifiable structure responsible for performing quality assurance functions within the MCO. This committee has:

A. Regular meetings -- The committee meets on a regular basis. The frequency of meetings is sufficient to demonstrate that the committee is following-up on all findings and required actions, but in no case are meeting less frequently than quarterly;

B. Established parameters for operating - The role, structure and function of the committee are specified;

C. Documentation -- There are records documenting the committee's activities, finding, recommendations and actions;

D. Accountability -- The QAP committee is accountable to the Governing Body and reports to it (or its designee) on a scheduled basis on activities, findings, recommendations and actions; and

E. Membership -- there is active participation on the Quality Assurance Committee from health plan providers, who are representative of the composition of the health plan's providers.

STANDARD V: QUALITY ASSURANCE PLAN SUPERVISION. There is a designated senior executive who is responsible for QAP implementation. The organization's Medical Director has substantial involvement in quality assurance activities.

STANDARD VI: ADEQUATE RESOURCES. The QAP has sufficient material resources; and staff with the necessary education, experience, or training; to effectively carry out its specified activities.

STANDARD VII: PROVIDER PARTICIPATION IN THE QUALITY ASSURANCE PLAN.

A. Participating physicians and other providers are kept informed about the written QAP.

B. The MCO includes in all its provider contracts and employment agreements, for both physicians and non-physician providers, a requirement securing cooperation with the QAP.

C. Contracts specify that hospitals and other contractors will allow the MCO access to the medical records of its members.

STANDARD VIII: DELEGATION OF QAP. The MCO remains accountable for all QAP functions, even if certain functions are delegated to other entities. If the MCO delegates any quality assurance activities to contractors:

A. There is a written description of: the delegated activities; the delegate's accountability for these activities; and the frequency of reporting to the MCO.

B. The MCO has written procedures for monitoring and evaluating the implementation of the delegated functions and for verifying the actual quality of care being provided.

C. There is evidence of continuous and ongoing evaluation of delegated activities, including approval of quality improvement plans and regular specified reports.

STANDARD IX: CREDENTIALING AND RECREDENTIALING. The QAP contains the following provisions to determine whether physicians and other health care professionals, who are licensed by the State and who are under contract to the MCO, are qualified to perform their services.

A. Written policies and procedures - The MCO has written policies and procedures for the credentialing process, which includes the organization's initial credentialing of practitioners, as well as its subsequent recredentialing, recertifying and/or reappointment of practitioners.

B. Oversight by governing body - The Governing Body, or the group or individual to which the governing body has formally delegated the credentialing function, has reviewed and approved the credentialing policies and procedures.

C. Credentialing entity - The plan designates a credentialing committee or other peer review body which makes recommendations regarding credentialing decision.

D. Process - The initial credentialing process obtains and reviews verification of the following information, at a minimum:

1. the practitioner holds a current valid license to practice;
2. valid DEA (Drug Enforcement Agency) or CDS (Controlled Dangerous Substances) certificate, as applicable;
3. graduation from medical school and completion of a residency, or other post-graduate training, as applicable;
4. work history;
5. professional liability claims history;
6. good standing of clinical privileges at the hospital designated by the practitioner as the primary admitting facility (This requirement may be waived for practices which do not have or do not need access to hospital.);
7. the practitioner holds current, adequate malpractice insurance according to the plan's policy;
8. any revocation or suspension of a state license or DEA (Drug Enforcement Agency) number;
9. any curtailment or suspension of medical staff privileges (other than for incomplete medical records);
10. any sanctions imposed by Medicare and/or Medicaid; and
11. any censure by the State or local Medical Association.
12. The organization requests information on the practitioner from the National Practitioner Data Bank and the State Department of Professional Licensing.
13. The application process includes a statement by the applicant regarding;
    a. any physical or mental health problems that may affect current ability to provide health care;
    b. history of loss of license and/or felony convictions;
    c. history of loss or limitation of privileges or disciplinary activity; and
    d. an attestation to correctness/ completeness of the application.

    This information should be used to evaluate the practitioners's current ability to practice.

E. Recredentialing - A process for the periodic reverification of clinical credentials (recredentialing, reappointment, or recertification) is described in the organization's policies and procedures.

1. There is evidence that the procedure is implemented at least every two years.

2. The MCO conducts periodic review of information from the National Practitioner Data Bank, along with performance data, on all physicians, to decide whether to renew the participating physician agreement. At a minimum, the recredentialing, recertification or reappointment process is organized to verify current standing on items listed in "D-l" through "D-12", above.

3. The recredentialing, recertification or reappointment process also includes review of data from:

   a. member complaints;

   b. results of quality reviews;

   c. utilization management;

   d. member satisfaction surveys; and

   e. reverification of hospital privileges and current licensure.

F. Delegation of credentialing activities - If the MCO delegates credentialing (and recredentialing, recertification, or reappointment) activities, there is a written description of the delegated activities, and the delegate's accountability for these activities. There is also evidence that the delegate accomplished the credentialing activities. The MCO monitors the effectiveness of the delegate's credentialing and reappointment or recertification process.

G. Retention of credentialing authority - The MCO retains the right to approve new providers and sites, and to terminate or suspend individual providers. The organization has policies and procedures for the suspension, reduction or termination of practitioner privileges.

H. Reporting requirement - There is a mechanism for, and evidence of implementation of, the reporting of serious quality deficiencies resulting in suspension or termination of a practitioner, to the appropriate authorities.

I. Appeals process - There is a provider appellate process for instances where the MCO chooses to reduce, suspend or terminate a practitioner's privileges with the organization.

STANDARD X: ENROLLEE RIGHTS AND RESPONSIBILITIES. The organization demonstrates a commitment to treating members in a manner that acknowledges their rights and responsibilities.

A. Written policy and enrollee rights. The organization has a written policy that recognizes the following rights of members:

1. to be treated with respect, and recognition of their dignity and need for privacy;

2. to be provided with information about the organization, its services, the practitioners providing care, and members rights and responsibilities;

3. to be allowed to choose practitioners, within the limits of the plan network, including the right to refuse care from specific practitioners;

4. to participate in decision-making regarding their health care;

5. to voice grievances about the organization or care provided;

6. to formulate advance directives; and

7. to have access to his/her medical records in accordance with applicable federal and state laws.

B. Written policy on enrollee responsibilities. The organization has a written policy that addresses members' responsibility for cooperating with those providing health care services. This written policy addresses members' responsibility for:

1. providing, to the extent possible, information needed by professional staff in caring for the member; and

2. following instructions and guidelines given by those providing health care services.

C. Communication of policies to providers - A copy of the organization's policies on members' rights and responsibilities is provided to all participating providers.

D. Communication of policies to enrollees/members - Upon enrollment, members are provided a written statement that includes information on the following:

1. rights and responsibilities of members;

2. benefits and services included and excluded as a condition of membership, and how to obtain them, including a description of:

   a. any special benefit provisions that may apply to service obtained outside the system; and

   b. the procedures for obtaining out-of-area coverage.

3. provisions for after-hours and emergency coverage;

4. the organization's policy on referrals for specialty care;

5. procedures for notifying those members affected by the termination or change in any benefits, services, or service delivery office/site;

6. procedures for appealing decisions adversely affecting the members's coverage, benefits, or relationship to the organization;

7. procedures for changing practitioners;

8. procedures for disenrollment; and

9. procedures for voicing complaints and/or grievances and for recommending changes in policies and services.

E. Enrollee/member grievance procedures. The organization has a system(s) for resolving members complaints and formal grievances. This system includes:

1. procedures for registering and responding to complaints and grievances in a timely fashion (organizations should establish and monitor standard for timeliness);

2. documentation of the substance of complaints or grievances, and actions taken;

3. procedures to ensure a resolution of the complaint or grievance;

4. aggregation and analysis of complaint and grievance data and use of the data for quality improvement; and

5. an appeal process for grievances.

F. Enrollee/member suggestions. Opportunity is provided for members to offer suggestions for changes in policies and procedures.

G. Steps to assure accessibility of services. The MCO takes steps to promote accessibility of services offered to members. These steps include:

1. points of access to primary care, specialty care, and hospital services are identified for members; and

2. at a minimum, members are given information about:

   a. how to obtain services during regular hours of operations,

   b. how to obtain emergency and after-hours care, and

   c. how to obtain the names, qualifications, and titles of the professionals providing and/or responsible for their care.

H. Cultural and ethnic sensitivity is shown to members when accessing and receiving care.

I. Written information for members. Written information provided to members must:

1. be written in prose that is readable and easily understood (for example, subscriber brochures, announcements, handbooks); and

2. be available, as needed, in the languages of the major population groups served-- a "major" population group is one which represents at least 10% of a plan's membership.

J. Confidentiality of patient information. The organization acts to ensure that the confidentiality of specific patient information and records is protected. The organization must:

1. establish in writing, and enforce, policies and procedures on confidentiality, including confidentiality of medical records;

2. ensure that patient care offices/sites have implemented mechanisms that guard against the unauthorized or inadvertent disclosure of confidential information to persons outside of

the medical care organization;

3. shall hold confidential all information obtained by its personnel about enrollees related to their examination, care and treatment and should not divulge it without the enrollee's authorization, unless

    a. it is required by law;

    b. it is necessary to coordinate the patient's care with physicians, hospitals, or other health care entities, or to coordinate insurance or other matters pertaining to payment; or

    c. it is necessary in compelling circumstances to protect the health or safety of an individual.

4. report to the patient in a timely manner any release of information in response to a court order; and

5. ensure that when enrollee records may be disclosed, whether or not authorized by the enrollee, to qualified personnel for the purpose of conducting scientific research, these organizations and personnel may not identify, directly or indirectly, any individual enrollee in any report of the research or otherwise disclose participant identity in any manner.

K. Treatment of minors. The organization has written policies regarding the appropriate treatment of minors.

L. Assessment of member satisfaction. The organization conducts periodic surveys of member satisfaction with its services. The surveys:

1. include content on perceived problems in the quality, availability, and accessibility or care;

2. assess at least a sample of:

    a. Medicaid members,

    b. Medicaid member requests to change practitioners and/or facilities, and

    c. disenrollment by Medicaid members;

3. and, as a result of the surveys, the organization:

    a. identifies and investigates sources of dissatisfaction,

    b. outlines action steps to follow-up on the findings, and

    c. informs practitioners and providers of assessment results; and

4. the organization reevaluates the effects of the above activities.

STANDARD XI: STANDARD FOR AVAILABILITY AND ACCESSIBILITY. The MCO has established standards for access (e.g., to routine, urgent and emergency care; telephone appointments; advice; and member service lines). Performance on these dimensions of access are assessed against the standards.

STANDARD XII: MEDICAL RECORD STANDARDS.

A. Accessibility and availability of medical records.

1. The MCO shall include provisions in provider contracts for appropriate access to the medical records of its enrollees for purposes of quality review.

2. Records are available to health care practitioners at each encounter.

B. Record keeping. Medical records may be on paper or electronic. The MCO takes steps to promote maintenance of medical records in a legible, current, detailed, organized and comprehensive manner that permits effective patient care and quality review.

1. Medical record standards. The organization sets standards for medical records. The records reflect all aspects of patient care, including ancillary services. These standards shall, at a minimum include requirements for:

   a. patient identification information -- each page or electronic file in the record contains the patient's name or patient ID number;

   b. personal/biographical data -- including age, sex, address, employer, home and work telephone numbers, and marital status;

   c. entry date -- all entries are dated;

   d. provider identification -- all entries are identified as to author;

   e. legibility -- the record is legible to someone other than the writer. Any record judged illegible by one physician reviewer should be evaluated by a second reviewer.

   f. allergies -- medication allergies and adverse reactions are prominently noted on the record absence of allergies (no known allergies -- NKA) is noted in an easily recognizable location;

   g. past medical history -- (for patients seen three or more times) past medical history is easily identified including serious accidents, operations, illnesses; for children, past medical history relates to prenatal care and birth;

   h. immunizations -- for pediatric records (ages 12 and under) there is a completed immunization record or a notation that immunizations are up-to-date;

   i. diagnostic information;

   j. medication information;

   k. identification of current problems-- significant illnesses, medical conditions and health maintenance concerns are identified in the medical record;

l. smoking/alcohol/substance abuse-- notation concerning cigarettes and alcohol use and substance abuse is present;

m. consultations, referrals and specialist reports -- notes from any consultations are in the record; consultation, lab, and x-ray reports filed in the chart have the ordering physician's initials or other documentation signifying review; consultation and significantly abnormal lab and imaging study results have an explicit notation in the record of follow-up plans;

n. emergency care;

o. hospital discharge summaries-- discharge summaries are included as part of the medical record for 1), all hospital admission which occur while the patient is enrolled in the MCO, and 2), prior admissions as necessary;

p. advance directive -- for medical records of adults, the medical record documents whether or not the individual has executed an advance directive which is a written instruction such as a living will or durable power of attorney for health care relating to the provision of health care when the individual is incapacitated;

2. Patient visit data. Documentation of individual encounters must provide adequate evidence of, at a minimum:

   a. history and physical examination-- appropriate subjective and objective information is obtained for the presenting complaints;

   b. plan of treatment;

   c. diagnostic tests;

   d. therapies and other prescribed regimens;

   e. follow-up -- encounter forms or notes have a notation, when indicated, concerning follow-up care, call or visit and the specific time to return is noted in weeks, months, or PRN, with unresolved problems from previous visits being addressed in subsequent visits;

   f. referrals and results thereof; and

   g. all other aspects of patient care, including ancillary services.

C. Record review process. The MCO:

1. has a system (record review process) to assess the content of medical records for legibility, organization, completion and conformance to its standards; and

2. the record assessment system addresses documentation of the items listed in XII(B), above.

STANDARD XIII: UTILIZATION REVIEW.

A. Written program description. The organization has a written utilization management program description which includes, at a minimum, procedures to evaluate medical necessity, criteria used, information sources and the process used to review and approve the provision of medical services.

B. Scope. The program has mechanisms to detect under utilization as well as over utilization.

C. Preauthorization and concurrent review requirements. For organization with preauthorization or concurrent review programs:

1. preauthorization and concurrent review decisions are supervised by qualified medical professionals;

2. efforts are made to obtain all necessary information, including pertinent clinical information, and consult with the treating physician as appropriate;

3. the reasons for decisions are clearly documented and available to the member;

4. there are well-publicized and readily available appeals mechanisms for both providers and patients. Notification of a denial includes a description of how to file an appeal;

5. decisions and appeals are made in a timely manner as required by the exigencies of the situation;

6. here are mechanisms to evaluate the effects of the program using data on member satisfaction, provider satisfaction or other appropriate measures; and

7. the organization has mechanisms, if it delegates responsibility for utilization management, to ensure that these standards are met by the delegate.

STANDARD XIV: CONTINUITY OF CARE SYSTEM. The MCO has put a basic system in place which promotes continuity of care and case management.

STANDARD XV: QUALITY ASSURANCE PLAN DOCUMENTATION.

A. Scope. The MCO shall document that it is monitoring the quality of care across all services and all treatment modalities, according to its written QAP.

B. Maintenance and availability of documentation. The MCO must maintain and make available to the State studies, reports, protocols, standards, worksheets, minutes, or such other documentation as may be appropriate, concerning its quality assurance activities and corrective actions.

STANDARD XVI: COORDINATION OF QUALITY ASSURANCE ACTIVITY WITH OTHER MANAGEMENT ACTIVITY. The findings, conclusions, recommendations, actions taken, and results of the actions taken as a result of quality assurance activity, are documented and reported to appropriate individuals within the organization and through established quality assurance channels.

A. Quality assurance information is used in recredentialing, recontracting and/or annual performance evaluations.

B. Quality assurance activities are coordinated with other performance monitoring activities, including utilization management, risk management, and resolution and monitoring of member complaints and grievances.

C. There is a linkage between quality assurance and the other management functions of the health plan such as:

1. network changes;
2. benefits redesign;
3. medical management systems (e.g. pre-certification);
4. practice feedback to physicians;
5. patient education; and
6. member services.

STANDARD XVII: DATA COLLECTION.

A. The MCO will submit information to DHCF using HEDIS (Health Plan Employer Data and Information Set) performance measures and reports. Data for measures of quality, utilization, member satisfaction and access will be reported for the plan in general as well as Medicaid specific.

B. Specific areas of study required will be stated in the contract with each individual MCO (See Attachment A).

C. Data or studies required by the contract must be submitted timely, be accurate and complete.

D. Studies involving grievance/complaint information, childhood immunization, prenatal and obstetrical care are required annually.

STANDARD XVIII: FINANCIAL SOLVENCY.

A. The MCO will submit their annual report as submitted to the Utah Department of Insurance.

B. The MCO will submit annually Measures of Financial Performance from the HEDIS report.

MONITORING ACCOUNTABILITY

An annual review will be conducted for all contracting MCO's. In addition DHCF will monitor and analyze complaints/grievances and periodically conduct patient satisfaction surveys.

If DHCF through quality assurance monitoring such as on-site reviews, MCO documentation review, data analysis, medical audits, or complaints/grievances determines that the MCO has not provided services in accordance with the contract or within expected professional standards, DHCF will request in

writing that the MCO correct the deficiencies or identified problems. The MCO will be given 15 calendar days to respond to the problem and develop a corrective action plan or appeal the DHCF findings. In complaint cases involving the need for medical record review, the MCO may send a written request to DHCF for extension of the time frames. If the MCO's plan requires revisions, as determined by the DHCF, the MCO will have 15 calendar days from the date the plan is returned by the DHCF to make revisions and resubmit the plan to the DHCF. If the MCO is unable or unwilling to develop a plan within 15 calendar days or to satisfactorily revise a plan within 15 calendar days, the MCO will be subject to the following sanctions:

> $500 for each day, beginning on the first day after the 15 day time period has expired, and continuing until the day a corrective action plan is submitted or a revised corrective action plan containing DHCF recommendations for implementation by the MCO is submitted.

If the MCO is unwilling or unable to implement a corrective action plan to the satisfaction of the DHCF by the date(s) included in the DHCF approved plan, the MCO will be subject to the following sanctions:

> $500 for each day, beginning on the first day after the DHCF determines that the MCO has not implemented the corrective action plan, and continuing until the day the MCO successfully demonstrates to the DHCF that it has implemented the plan; and other remedies included in the general provisions of the contract.

Any financial sanctions assessed by the DHCF will be deducted from the monthly payment to the MCO.

ATTACHMENT A

Areas for Studies and Reviews

Required studies will be listed in the Managed Care Organization (MCO) contract with the Utah Division of Health Care Finance (DHCF) as determined by the Managed Health Care and MCO staff. Amendments to the contract may be made as necessary during the contract period. Additional studies will be conducted by an external quality review organization (EQRO). Determination of study subjects will by made by the DHCF/Managed Health Care staff with input from the EQRO and the contracting MCOs.

Clinical Areas of Concern:

1. Childhood Immunizations (Required)
2. Pregnancy (Required)
3. Breast Cancer/Mammography
4. Cervical Cancer/Pap Smears
5. Lead toxicity/Screening
6. Comprehensive Well Child Periodic Health Assessment
7. HIV Status
8. Asthma
9. Hysterectomies
10. Diabetes
11. Hypertension
12. Sexually Transmitted Diseases
13. Heritable Diseases (newborn screens)
14. Coronary Artery Disease
15. Motor Vehicle Accidents
16. Pregnancy prevention
17. Tuberculosis
18. Failure to thrive
19. Hepatitis B
20. Otitis Media
21. Prescription Drug Abuse
22. Hip Fractures
23. Cholesterol Screening and Management
24. Treatment of Myocardial Infarctions
25. Prevention of Influenza
26. Smoking Prevention and Cessation
27. Hearing and Vision Screening and Services for Individuals Less Than 21 Years of Age
28. Dental Screening and Services for Individuals Less Than 21 Years of Age
29. Domestic Violence

Health Services Delivery Areas of Concern:

1. Access to care
2. Utilization of services
3. Coordination of care
4. Continuity of care

5. Health Education
6. Emergency services

The EQRO may periodically conduct the following reviews at the request of Managed Health Care Staff.

1. Sterilizations
2. Abortions
3. Children with multiple medical problems

ATTACHMENT B

Quality Review Process

If the MCO is accredited by a nationally recognized accreditation board, DHCF will accept that as compliance in the following standards.

Standard III:	Accountability to the Governing Body
Standard IV:	Active Quality Assurance Committee
Standard V:	Quality Assurance Plan Supervision
Standard VI:	Adequate Resources
Standard VII:	Provider Participation in the Quality Assurance Plan
Standard VIII:	Delegation of Quality Assurance Plan Activities
Standard IX:	Credentialing and Recredentialing
Standard XII:	Medical Records Standards
Standard XIII:	Utilization Review
Standard XIV:	Continuity of Care System
Standard XVI:	Coordination of Quality Assurance Activity with Other Management Activity

The following standards will be reviewed annually by DHCF staff:

Standard I:	Written Quality Assurance Plan Description
Standard II:	Systematic Process of Quality Assessment and Improvement
Standard X:	Enrollee Rights and Responsibilities
Standard XI:	Standard For Availability and Accessibility
Standard XV:	Quality Assurance Plan Documentation
Standard XVII:	Data Collection
Standard XVIII:	Financial Solvency

If the MCO is not accredited by a nationally recognized accreditation board, DHCF staff will monitor all standards.

ATTACHMENT C

Monitoring Work Sheet

The ...[following] work sheets will be used to monitor all MCOs contracting with the Utah Division of Health Care Finance. It is the responsibility of the MCO to submit a plan of correction for any deficiencies identified. List of Work Sheets:

Standard I:	Written Quality Assurance Plan Description
Standard II:	Systematic Process of Quality Assessment and Improvement
Standard III:	Accountability to the Governing Body
Standard IV:	Active Quality Assurance Committee
Standard V:	Quality Assurance Plan Supervision and Standard VI: Adequate Resources
Standard VII:	Provider Participation in the Quality Assurance Plan and Delegation of Quality Assurance Plan Activities
Standard VIII:	Delegation of Quality Assurance Plan Activities
Standard IX:	Credentialing and Recredentialing
Standard X:	Enrollee Rights and Responsibilities
Standard XI:	Standard for Availability and Accessibility
Standard XII:	Medical Records Standards
Standard XIII:	Utilization Review
Standard XIV:	Continuity of Care System and
Standard XV:	Quality Assurance Plan Documentation
Standard XVI:	Coordination of Quality Assurance Activity with Other Management Activity
Standard XVII:	Data Collection
Standard XVIII:	Financial Solvency

STANDARD I -- WRITTEN QUALITY ASSURANCE PLAN DESCRIPTION

Contractor:_____________________ Review Date:_____________

Reviewer Signature:___________________________________

1. MET NOT MET The QAP contains a detailed set of objectives that are developed annually and include a timetable for implementation and accomplishment.

2. MET NOT MET The QAP is comprehensive in scope and provides for review of the entire range of care (clinical as well as non-clinical) provided under the contract. The needs of all demographic groups are considered in the QAP.

3. MET NOT MET The QAP specifies activities to be undertaken, methodologies to be used and individuals responsible for implementing them. The activities undertaken are on a continuing basis with tracking of issues over time.

4. MET NOT MET The QAP provides for review of the process followed by health professionals and feedback to the health professionals on the results of the review.

5. MET NOT MET The QAP methodology addresses health outcomes to the extent consistent with existing technology.

6. MET NOT MET The contractor regularly monitors provider and subcontractor performance/compliance with program policies and contractual requirements.

Comments:____
____
____

STANDARD II -- SYSTEMATIC PROCESS OF QUALITY ASSESSMENT AND IMPROVEMENT

Contractor:___________________________ Date:_________

Reviewer Signature:____________________________________

1. MET NOT MET The QAP specifies the clinical or health services delivery areas to be monitored, which includes certain priority areas of concern selected by the DHCF for Medicaid clients and reflects the population served in terms of age groups, disease categories and special risk status.

2. MET NOT MET The QAP identifies and utilizes quality indicators that are objective, measurable and based on current knowledge and clinical experience.

3. MET NOT MET Clinical care standards or practice guidelines are used to monitor the quality of care provided. The standards used are based upon reasonable scientific evidence and are included in provider education materials.

4. MET NOT MET There is on-going analysis of care and services by appropriate clinical and/or multidisciplinary teams. Areas requiring improvement are identified.

5. MET NOT MET Data from studies required in the contract with the Medicaid Agency are submitted in the format and time frames specified in the contract.

6. MET NOT MET Standards/guidelines used focus on the process and outcomes of health care delivery, as well as access to care.

7. MET NOT MET Standards/guidelines address preventive health services.

8. MET NOT MET There is a mechanism in place for continuously updating the standard/guidelines.

9. MET NOT MET The QAP includes procedures for remedial action when deficiencies are identified. It specifies the types of problem requiring corrective action, the individuals responsible for making final determinations regarding quality problems, the actions to be taken, provision for providing feedback to appropriate individuals, the next steps should improvement not occur and procedures and conditions for terminating a provider.

10. MET NOT MET The QAP includes provisions for monitoring and evaluation of corrective actions to ensure that actions for improvement have been effective.

11. MET NOT MET The organization routinely evaluates the QAP and produces quality assurance reports.

12. MET NOT MET Written reports on the QAP are prepared that address: Quality assurance studies and other activities completed; trending of clinical and service indicators and other performance data; demonstrated improvement in quality; areas of deficiency and recommendations for corrective action; and an evaluation of the overall effectiveness of the QAP. Reports are submitted to the Medicaid Agency in accordance with the contract.

Comments:____
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____

STANDARD III -- ACCOUNTABILITY TO THE GOVERNING BODY;

Contractor:______________________ Date:__________ Met By Accreditation:___

Reviewer Signature:__________________________________

1. MET NOT MET There is documentation that the Governing Body has approved the overall QAP and an annual QAP.

2. MET NOT MET There is evidence that the Governing Body has formally designated an accountable entity or entities to provide oversight and quality assurance.

3. MET NOT MET There is evidence that the Governing Body receives written progress reports of the activities of the QAP and directs that the operational QAP be modified on an ongoing basis to accommodate review findings and issues of concern.

Comments:____
____
____

Standard IV -- ACTIVE QUALITY ASSURANCE COMMITTEE

Contractor:________________________ Date:________Met By Accreditation:____

Reviewer Signature:_________________________________

1. MET NOT MET The QAP delineates an identifiable structure responsible for performing quality assurance functions.

2. MET NOT MET There is evidence that the committee or other structure has regular meetings, established parameters for operating, documentation of activities, and active participation of providers who are representative of the composition of the health plan's providers.

Comments:____
____
____

STANDARD V -- QUALITY ASSURANCE PLAN SUPERVISION

Contractor:____________________Date:___________ Met By Accreditation:________

Reviewer Signature:_________________________________

1. MET NOT MET There is a designated senior executive who is responsible for program implementation.

2. MET NOT MET The medical director is actively involved in the administration of the plan.

3. MET NOT MET There is evidence that the medical director is actively involved in peer review/education.

4. MET NOT MET The medical director is readily available to staff to provide daily consultation.

Comments:____
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STANDARD VI -- ADEQUATE RESOURCES

Contractor:_______________________ Date:_______Met By Accreditation:_________

Reviewer Signature:____________________________________

1. MET NOT MET The QAP staffing conforms with usual and customary industry practices.

2. MET NOT MET The organization has established contingency plans to fulfill the responsibilities of any vacant key positions.

3. MET NOT MET There is evidence of open communication between divisions within the plan such as: provider services, member services, contracting, planning and management.

4. MET NOT MET Managers/staff from the above specialty division participate in planning and quality improvement activities.

Comments:____
____
____

STANDARD VII -- PROVIDER PARTICIPATION IN THE QUALITY ASSURANCE PLAN

Contractor:____________________ Date:________Met By Accreditation:________

Reviewer Signature:__________________________________

1. MET NOT MET All providers both physician and non-physician are aware of the QAP and kept apprised of quality assurance activities.

2. MET NOT MET All provider contracts/agreements require cooperation with the QAP.

3. MET NOT MET All contracts/agreements require access to medical records of enrollees.

Comments:____
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STANDARD VIII -- DELEGATION OF QUALITY ASSURANCE PLAN ACTIVITIES

Contractor:______________________ Date:______Met By Accreditation:_________

Reviewer Signature:___________________________________

1. MET NOT MET N/A QAP activities delegated to contractors include a written description of activities and the delegates accountability for the activities.

2. MET NOT MET N/A There is evidence that there is continuous and ongoing evaluation of the delegated activities by the MCO.

Comments:____
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STANDARD IX -- CREDENTIALING AND RECREDENTIALING

Contractor:_____________________Date:__________Met By Accreditation:________

Reviewer Signature:____________________________________

1. MET NOT MET The contractor has written credentialing standards and/or procedures.

2. MET NOT MET The credentialing activities include the following:

   Yes No Verification of licensure

   Yes No Verification of board and specialty certification

   Yes No Verification of acceptable levels of malpractice coverage

   Yes No Evaluation of practice history, particularly related to participation in the Medicaid program

   Yes No Verification of hospital admitting privileges

3. MET NOT MET The contractor has an established recredentialing process.

4. MET NOT MET The recredentialing process includes the same elements as the initial credentialing process. (Note differences in comment section)

5. MET NOT MET Board certification or board admissibility is required for specialists.

6. MET NOT MET There are procedures in place to identify/address situations where a participating physician loses licensure, admitting privileges, or board certification.

Comments:____
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____

STANDARD X -- ENROLLEE RIGHTS AND RESPONSIBILITIES

Contractor:___________________Date:_________________

Reviewer Signature:_________________________________

1. MET NOT MET There is an established member services function.

2. MET NOT MET Member service representatives are qualified.

3. MET NOT MET Multilingual service representatives are available as necessary.

4. MET NOT MET Members are informed of the availability/role of member services.

5. MET NOT MET Members services handbooks are issued upon enrollment.

6. MET NOT MET Written materials are accurate and appropriate (e.g. available in foreign languages and low reading levels when necessary).

7. MET NOT MET Member services handbooks inform members of all relevant policies and procedures and include information on obtaining further explanations.

8. MET NOT MET Updated handbooks are regularly distributed to existing members.

9. MET NOT MET If the contractor disseminates a newsletter to members, it is distributed to Medicaid enrollees, also.

10. MET NOT MET Members are presented written and oral information on appropriate utilization of services, prior authorization procedures, appropriate use of the emergency room, use of out-of-plan services, and obtaining care when outside the plan's service area.

11. MET NOT MET Written materials that describe coverage and how to access services include a contact person to call if the enrollee has difficulty understanding the procedures.

12. MET NOT MET Written policies/procedures are followed.

13. MET NOT MET Changes in primary care providers are processed promptly and in accordance with contractual requirements.

14. MET NOT MET Member service representative appropriately address inquiries from members.

15. MET NOT MET The contractor offers health education programs for members and these programs are based on a needs assessment of Medicaid members.

16. MET NOT MET Health education programs are accessible to Medicaid members considering such factors as cost, location, child care, etc.

17. MET NOT MET The contractor regularly evaluates the effectiveness of its health promotion activities and such activities are restructured as a result of such evaluations.

18. MET NOT MET The contractor conducts out reach efforts to: 1) enhance pediatric preventive care; 2) promote early access to prenatal care services; 3) promote early diagnosis and treatment for HIV disease; and 4) promote use of other preventive services, such as family planning.

19. MET NOT MET Protocols for non-compliant members are present.

20. MET NOT MET The contractors written complaint/grievance procedures are consistent with those approved by Medicaid. (Note discrepancies in "comments" section)

21. MET NOT MET Complaints and/or grievances filed within the past contract year were handled in accordance with approved procedures.

22. MET NOT MET Grievances are effectively tracked.

23. MET NOT MET Grievances are handled in a timely manner

24. MET NOT MET Unresolved grievances are promptly referred to Medicaid for resolution.

25. MET NOT MET Complaints and/or grievances are reported to the contractor's quality assurance committee.

26. MET NOT MET Member services representative actively participate in complaint/grievance resolution.

27. MET NOT MET Employees, providers, and subcontractors are aware of the grievance policies and procedures.

28. MET NOT MET Members have received written copies of the complaint/grievance procedures.

29. MET NOT MET Materials distributed to members include the following:

   Yes No Titles and telephone numbers of individuals to whom a grievance should be directed;

   Yes No Where and how to obtain any forms or documentation that may be necessary;

   Yes No How and with whom a face-to-face meeting can be held to

discuss the complaint/grievance;

Yes No The appeals process and options available in the event that the enrollee is not satisfied with contractor's response (including an appeal to the Medicaid agency and the right to a fair hearing) and the time frames to be followed in responding to the initial grievance and any appeals;

Yes No Titles of the personnel participating in the process who have the authority to require corrective action; and

Yes No An explanation of applicable time frames.

30. MET NOT MET The member is advised in writing of the status/outcome of the complaint or grievance and of the next step in the process if the issue is not resolved.

31. MET NOT MET The contractor regularly inform members about changes in the grievance procedures.

32. MET NOT MET There is evidence that the primary care providers understand member complaint/grievance procedures.

33. MET NOT MET Recorded grievances identify areas for improvement in the contractor's policies and procedures, provider network, benefits design, etc. When areas are identified, the information is incorporated into the contractor's quality assurance activities.

34. MET NOT MET The quality assurance committee evaluates if there is a correlation between complaint/grievances and disenrollment from coordinated care.

35. MET NOT MET The policies and procedures used by the contractor safeguard client information including: name, address, medical services provided, social and economic circumstances, agency evaluation of personal information, medical data (including diagnosis) and information related to medical assistance eligibility and third party coverage.

36. MET NOT MET The contractor has written policies/procedures that address the use and disclosure of information concerning Medicaid enrollees.

37. MET NOT MET The types of information to be safeguarded and the conditions for release of safeguarded information is clearly defined.

38. MET NOT MET There are procedures in place to protect against unauthorized disclosure.

39. MET NOT MET The records regarding family planning services are kept confidential.

40. MET NOT MET There are written policies regarding the appropriate treatment of minors.

41. MET NOT MET The plan conducts patient satisfaction surveys at least yearly.

42. MET NOT MET The results of the survey of Medicaid member satisfaction compares

favorably with results of the survey of commercial members.

43. MET NOT MET The survey results do not indicate critical areas for further investigation/ action. If indications present explain in comment section.

44. MET NOT MET Enrollees change primary care providers at a frequency comparable to other plans.

45. MET NOT MET Enrollees disenroll from the plan at a rate comparable to enrollees of other plans.

Comments:____
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____

STANDARD XI -- STANDARD FOR AVAILABILITY AND ACCESSIBILITY

Contractor:__________________________Date:___________

Reviewer Signature:____________________________________

1. MET NOT MET There are established standards for access (e.g., to routine, urgent and emergency care, telephone appointments; advice; and member service lines).

2. MET NOT MET There is an effective system for authorizing care (prompt and appropriate authorization).

3. MET NOT MET There is an effective system for monitoring follow-up care.

4. MET NOT MET Member service telephone calls are answered promptly.

5. MET NOT MET Non-English speaking members and hearing impaired members can reach a member services representative by telephone.

6. MET NOT MET The availability of materials in languages other than English is sufficient to meet the needs of the eligible population.

7. MET NOT MET Staff is educated in ways to show cultural and ethnic sensitivity to members.

8. MET NOT MET Member services representatives assist members in their selection of primary care providers.

9. MET NOT MET The contractor has agreements in place with primary care practitioners, specialists, hospitals, home health agencies, pharmacies, and other providers of services offered to plan members.

10. MET NOT MET Special population groups are accessing needed services.

11. MET NOT MET The contractor has appropriate linkages to social service agencies to be used

with their case management services.

12. MET NOT MET Providers are located near mass transportation (at least to the extent that non-plan Medicaid providers are located near transportation).

13. MET NOT MET Provider facilities are accessible to individuals with limited mobility and other disabilities.

14. MET NOT MET The contractor accepts new enrollees in the order they apply until reaching full capacity.

15. MET NOT MET There is no evidence of discrimination in marketing practices related to health status or health care needs (i.e., use of a pre-enrollment "health screening" form).

16. MET NOT MET Members have a choice of at least two primary care physicians- -within a specified radius of their residence (i.e., 40 miles/40 minutes).

17. MET NOT MET The contractor has written standards for clinically appropriate waiting times for medical appointments.

18. MET NOT MET The contractor regularly monitors waiting times.

19. MET NOT MET The contractor has a formal outreach effort targeted to pregnant women.

20. MET NOT MET The contractor has a mechanism to identify pregnant women already enrolled in the plan and to help them enter prenatal care.

21. MET NOT MET The contractor has a mechanism established to track the prenatal care that pregnant members receive.

22. MET NOT MET The contractor has protocols established to follow up on members who do not comply with prenatal care visits.

23. MET NOT MET The contractor assigns an obstetrician or other qualified provider to pregnant women on enrollment, or in a timely manner as soon as the pregnancy is identified.

24. MET NOT MET The contractor has mechanisms to ensure early entry to care for pregnant women.

25. MET NOT MET The plan's percentage of sick newborns relative to total births have decreased. (Trend and not a single reporting period phenomenon)

26. MET NOT MET The contractor monitors provider compliance with CHEC/EPSDT requirements.

27. MET NOT MET The contractor provides training and education on CHEC/EPSDT requirements to providers and their staff.

28. MET NOT MET All members are notified of CHEC/EPSDT screening services and notified in

writing when appointments need to be scheduled.

29. MET NOT MET Referrals are tracked to ensure that members receive needed care.

30. MET NOT MET Follow-up tracking is done on members who do not make appointments or keep appointments to investigate any low penetration of CHEC/EPSDT services (i.e. outreach plans for protocols for the age group which is not seeking services).

31. MET NOT MET Outreach programs are being actively developed to encourage eligible members to utilize available services.

32. MET NOT MET A sufficient sample of CHEC/EPSDT charts are audited on a regular basis.

33. MET NOT MET System management reports and other utilization reports are reviewed in the health plan's assessment of the effectiveness and utilization of CHEC/EPSDT services.

34. MET NOT MET The contractor enforces policies and procedures that protect the client's freedom to choose any qualified provider of family planning services.

35. MET NOT MET Family planning services are geographically accessible to each member in the health plan's service area.

36. MET NOT MET The member's participation in family planning services (utilization of services) are on a voluntary basis, and not a prerequisite to eligibility or receipt of other services.

37. MET NOT MET The medical care components of family planning services are overseen by the plan's medical director.

38. MET NOT MET The contractor's network contains physicians with special training or experience in family planning services.

39. MET NOT MET The contractor has developed written protocols that detail specific procedures for the provision of each family planning service offered.

40. MET NOT MET Hysterectomies and sterilization procedures are conducted according to Federal and State regulation.

41. MET NOT MET The contractor has developed measures to monitor the utilization of family planning services.

42. MET NOT MET Utilization data regarding family planning services is monitored by the contractor.

Comments:____

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STANDARD XII -- MEDICAL RECORDS STANDARDS

Contractor:_____________________Date:________Met By Accreditation:________

Reviewer Signature:____________________________________

1. MET NOT MET The contractor has written procedures for record keeping.

2. MET NOT MET The medical records keeping system is designed to capture the following information:

   - Yes No Enrollee identifiers (i.e. name, date of birth, and enrollee identification number)
   - Yes No Whether or not the patient has written an advance directive.
   - Yes No Patient background and medical history including allergies, immunizations, and medication information.
   - Yes No Date of service
   - Yes No Description of service
   - Yes No Place of service
   - Yes No Date of request/referral
   - Yes No Name of servicing provider(s)
   - Yes No Name of referring provider, if applicable
   - Yes No Diagnosis
   - Yes No The terms of any referrals/authorization made by the primary care physician (i.e. number of visits authorized, open ended referral vs. specified number of visits)
   - Yes No Documentation of emergency care, hospital discharge summaries, ancillary services
   - Yes No Clinical indicators
   - Yes No Outcome measures

3. MET NOT MET All entries in the medical record are dated and all authors identified.

4. MET NOT MET Records are available to providers at each patient encounter.

5. MET NOT MET Records are maintained for the amount of time specified in the contract.

6. MET NOT MET Records (medical, financial, enrollment, disenrollment, administrative, quality assurance and operating records) are accessible to personnel and government authorities as necessary and appropriate.

Comments:____
____
____

STANDARD XIII -- UTILIZATION REVIEW

Contractor:_________________ Date:______Met By Accreditation:_________

Reviewer Signature:_______________________________

1. MET NOT MET The contractor has written policies and procedures describing its utilization review program.

2. MET NOT MET The contractor has a formally established utilization review committee.

3. MET NOT MET Appropriate medical consultants participate in the UR committee.

4. MET NOT MET The utilization review system include the following components.

Yes No Prior approval review

Yes No Second opinion program

Yes No Concurrent review

Yes No Discharge planning

Yes No Physician profile reports

Yes No Trend reports

Yes No Identification of patterns of care

Yes No Tracking of clinical indicators

Yes No Referral tracking

5. MET NOT MET The UR program identifies both over and under utilization.

6. MET NOT MET The contractor's outreach activities are sufficient given the size of the plan.

7. MET NOT MET The Contractor's utilization review program is effective.

8. MET NOT MET There are sufficient qualified personnel/resources devoted to utilization review.

9. MET NOT MET The contractor regularly evaluate the effectiveness of the utilization review program.

10. MET NOT MET Members receive necessary and appropriate services.

11. MET NOT MET Enrollees receive appropriate diagnostic test and specialty referrals.

12. MET NOT MET Preauthorization and concurrent review decisions are supervised by qualified medical professionals.

13. MET NOT MET Efforts are made to obtain all necessary information and consult with the treating physician as appropriate during preauthorization and concurrent review.

14. MET NOT MET Reasons for decisions are clearly documented and available to the member.

15. MET NOT MET Providers and members are informed of the utilization review appeals process.

16. MET NOT MET Appeals are handled in a timely manner.

17. MET NOT MET Analysis of data from the UR system is part of the quality assurance process.

18. MET NOT MET Utilization review activities reflect use of alternative health care services in lieu of hospitalization.

19. MET NOT MET Physician profiling is part of the utilization review process.

20. MET NOT MET The physician profile information is shared with plan providers for educational purposes.

Comments:____
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STANDARD XIV -- CONTINUITY OF CARE SYSTEM

Contractor:____________________Date:_______Met By Accreditation:________

Reviewer Signature:___________________________________

1. MET NOT MET There is a basic system in place to assure continuity of care to all enrollees.

2. MET NOT MET There is a case management system in place to assist enrollees requiring these services.

Comments:____
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____

STANDARD XV -- QUALITY ASSURANCE PLAN DOCUMENTATION

Contractor:_________________________Date:____________

Reviewer Signature:____________________________________

1. MET NOT MET There is documentation that the MCO is monitoring the quality of care across all services and all treatment modalities, according to its written QAP.

2. MET NOT MET Documentation of QAP activities including corrective actions is maintained and available for review by the State Agency or its designee. (studies, protocols, standards, meeting minutes, reports, worksheets, etc.)

Comments:____
____
____

STANDARD XVI -- COORDINATION OF QUALITY ASSURANCE ACTIVITY WITH OTHER MANAGEMENT ACTIVITY

Contractor:___________________Date:_______Met By Accreditation:________

Reviewer Signature:_________________________________

1. MET NOT MET The quality assurance activities are coordinated with other performance monitoring activities.

2. MET NOT MET There is linkage between quality assurance and the other management functions of the health plan, such as network changes, benefits redesign, medical management systems, physician education and patient education.

3. MET NOT MET Data from the utilization review system is used to educate providers regarding norms and expected utilization patterns.

4. MET NOT MET Utilization review findings are incorporated into quality assurance activities, provider recredentialing activities and long range planning.

Comments:____
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____

STANDARD XVII -- DATA COLLECTION

Contractor:____________________ Date:___________

Reviewer Signature:__________

1. MET NOT MET The data provided is in accordance with contract requirements.

2. MET NOT MET Membership reports are timely, accurate and complete:

   Yes No Enrollment data

   Yes No Disenrollment summaries (reasons for leaving plan)

   Yes No Outreach activities

   Yes No Satisfaction surveys

   Yes No Grievance reports

3. MET NOT MET Quality assurance/access reports are timely, accurate and complete.

Comments:____
____
____

STANDARD XVIII -- FINANCIAL SOLVENCY

Contractor:________________________Date:___________

Reviewer Signature:_________________________________

1. MET NOT MET The contractor complies with requirements to allow inspection/audit of financial records.

2. MET NOT MET The contractor is found to be financially solvent by the Utah State Insurance Commission.

Comments:____
____
____

WORK SHEET TOTALS

MET	NOT MET		STANDARD
___	____	Standard I	- Written Quality Assurance Plan Description
___	____	Standard II	- Systematic Process of Quality Assessment and Improvement
___	____	Standard III	- Accountability to the Governing Body
___	____	Standard IV	- Active Quality Assurance Committee
___	____	Standard V	- Quality Assurance Plan Supervision
___	____	Standard VI	- Adequate Resources
___	____	Standard VII	- Provider Participation and Delegation of Quality Assurance Plan Activities
___	____	Standard VIII	- Delegation of Quality Assurance Plan Activities
___	____	Standard IX	- Credentialing and Recredentialing
___	____	Standard X	- Enrollee Rights and Responsibilities
___	____	Standard XI	- Availability and Accessibility
___	____	Standard XII	- Medical Records
___	____	Standard XIII	- Utilization Review
___	____	Standard XIV	- Continuity of Care System
___	____	Standard XV	- Quality Assurance Plan Documentation
___	____	Standard XVI	- Coordination of Quality Assurance Activity with other Management Activity
___	____	Standard XVII	- Data Collection
___	____	Standard XVIII	- Financial Solvency

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___ ____ TOTAL

Comments:____

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NOTES

UTAH DEPARTMENT OF HEALTH
288 North 1460 West, Salt Lake City, Utah 84116

CONTRACT AMENDMENT

H9920205-01	00-6146
Department Log Number	State Contract Number

1. CONTRACT NAME:
   The name of this Contract is HMO-AMERICAN FAMILY CARE the Contract number assigned by the State Division of Finance is 00-6146 the Department log number assigned by the Utah Department of Health is H9920205, and this Amendment is number 01.

2. CONTRACTING PARTIES:
   This Contract Amendment is between the Utah Department of Health (DEPARTMENT), and American Family Care (CONTRACTOR).

3. PURPOSE OF CONTRACT AMENDMENT:
   To add rural counties to the Contractor's service area effective January 1, 2000; to establish rates specifically for the rural counties, and to increase the Contract amount from $ [*] to $ [*]

4. CHANGES TO CONTRACT:

   A. Under Page 1, Item 4, CONTRACT AMOUNT is changed to read:
   "The Contractor will be paid up to a maximum amount of $ [*] for the Contract period in accordance with the provisions in this Contract. This Contract is funded with 71.61% Federal funds and with 28.39% State funds. The CFDA # is 93.778 and relates to the federal funds provided."

   B. Under Page 1, Item 6, REFERENCE TO ATTACHMENTS INCLUDED AS PART OF THIS CONTRACT is amended by adding Attachment F-1, Rates and Rate Related Terms for the Rural counties.

   C. Under Attachment B, Special Provisions, Article II, Service Area is changed to read:
   "The Service Area is limited to the urban counties of Davis, Salt Lake, Utah and Weber, and the rural counties of Box Elder, Cache, Beaver, Garfield, Iron, Kane, and Washington."

   D. Attachment F-1, Rates and Rate-Related Terms for the Rural Counties is added to the Contract as attached to this Amendment.

   E. All other provisions of the Contract remain unchanged.

5. If the Contractor is not a local public procurement unit as defined by the Utah Procurement Code (UCA Section 63-56-5), this Contract Amendment must be signed by a representative of the State Division of Finance and the State Division of Purchasing to bind the State and the Department to this Contract Amendment.

6. This Contract, its attachments, and all documents incorporated by reference constitute the entire agreement between the parties and supercede all prior negotiations, representations, or agreements, either written or oral between the parties relating to the subject matter of this Contract.

IN WITNESS WHEREOF, the parties sign this Contract Amendment.

CONTRACTOR: AMERICAN FAMILY CARE		UTAH DEPARTMENT OF HEALTH	
By: /s/ Kirk Olsen	4 Jan 2000	By: /s/ Shari A. Watkins,	01/07/2000
Signature of Authorized Individual	Date	Shari A. Watkins, C.P.A. Director Official of Fiscal Operations	Date
Print Name: Kirk Olsen		[SEAL]	1/7/00
		State Finance:	Date
Title: Chief Executive Officer		/s/ [ILLEGIBLE]	1/7/2000
33-0617992		State Purchasing:	Date
Federal Tax Identification Number or Social Security Number			

ATTACHMENT F-1 RURAL RATES AND RATE-RELATED TERMS

Effective January 1, 2000

AMERICAN FAMILY CARE

A. PREMIUM RATES

7. MONTHLY PREMIUM RATES BASED ON ENROLLEES' RATE CELLS

Age 0 to 1	TANF Male 1 to 21	TANF Male 21 & Over	TANF Female 1 to 21	TANF Female 21 & Over	Aged
$ [*]	$ [*]	$ [*]	$ [*]	$ [*]	$ [*]

Disabled Male	Disabled Female	Medically Needy Child	Medically Needy Adult	Non TANF Pregnant F	Restriction Program
$ [*]	$ [*]	$ [*]	$ [*]	$ [*]	$ [*]

8. SPECIAL RATE

An AIDS rate of $[*] per month will be paid in addition to the regular monthly premium when the T-Cell count is below 200.

B. PER DELIVERY REIMBURSEMENT SCHEDULE

The DEPARTMENT shall reimburse the CONTRACTOR $[*] per delivery to cover all Medically Necessary antepartum care, delivery, and postpartum professional, facility and ancillary services. The monthly premium amount for the enrollee is in addition to the delivery fee. The delivery payment will be made when the delivery occurs at 22 weeks or later, regardless of viability.

C. CHEC SCREENING INCENTIVE CLAUSE

1. CHEC Screening Goal

The CONTRACTOR will ensure that Medicaid children have access to appropriate well-child visits. The CONTRACTOR will follow the Utah EPSDT (CHEC) guidelines for the periodicity schedule for well-child protocol. The federal agency, Health Care Financing Administration, mandates that all states have 80% of all children screened. The DEPARTMENT and the CONTRACTOR will work toward that goal.

2. Calculation of CHEC Incentive Payment

The DEPARTMENT will pay the CONTRACTOR $ [*] for each percentage point over 60% achieved by the CONTRACTOR. The DEPARTMENT will calculate the CONTRACTOR'S annual participation rate based on information supplied by the CONTRACTOR under the EPSDT (CHEC) reporting requirements at the same time each federal fiscal year's HCFA-416 is calculated. Payment will be based on the percentages determined at that time.

3. CONTRACTOR's Use of Incentive Payment

The CONTRACTOR agrees to use this incentive payment to reward the CONTRACTOR's employees responsible for improving the EPSDT (CHEC) participation rate.

D. STOP-LOSS/REINSURANCE POLICY

Stop-loss under item #1 below will be administered by a reinsurer, TransAmerica Occidental Life Insurance Company (TransAmerica). TransAmerica will partially administer stop-loss under item #2 below.

1. REINSURANCE (all services including kidney, liver, and cornea and excluding specific organ transplantations defined in D.2. below)

Costs, net of TPL, for all inpatient and outpatient services listed in Attachment C (including kidney, liver, and cornea transplantations, but excluding bone marrow, heart, intestine, lung, pancreas, small bowel, combination heart/lung, combination intestine/liver, combination kidney/pancreas, multi visceral, combination liver/small bowel, any additional approved transplantations) that are covered on the date of service rendered and incurred from July 1, 1999 through June 30, 2000 by the MCO for an Enrollee shall be shared by Transamerica under the following conditions:

a. the date of service is from July 1, 1999 through June 30, 2000 (based on date of discharge if inpatient hospital stay);

b. paid claims incurred by the MCO exceed $50,000; and

c. services shall have been incurred by the MCO during the time the client is enrolled with the MCO.

If the above conditions are met, TransAmerica shall bear [*]% and the MCO shall bear [*]% of the amount that exceeds $50,000.

2. STOP-LOSS/REINSURANCE FOR SPECIFIC ORGAN TRANSPLANTATIONS

Costs, net of TPL, for bone marrow, heart, intestine, lung, pancreas, small bowel, combination heart/lung, combination intestine/liver, combination kidney/pancreas, multi visceral, combination liver/small bowel, and any additional approved transplantations (other than kidney, liver, and cornea) that are covered on the date of service rendered and incurred from July 1, 1999 through June 30, 2000 by the MCO for an Enrollee shall be shared by the DEPARTMENT, Transamerica and the MCO under the following conditions:

a. the date of service is from July 1, 1999 through June 30, 2000 (based on date of discharge if inpatient hospital stay);

b. paid claims incurred by the MCO exceed $40,000; and

c. services shall have been incurred by the MCO during the time the client is enrolled with the MCO;

d. the stop-loss billings for the first $40,000 must be submitted to the DEPARTMENT in a format mutually agreed upon; and

e. stop-loss billings for the first $40,000 must be submitted to the DEPARTMENT within six months of the end of the Contract year.

If the above conditions are met, the DEPARTMENT shall reimburse the MCO the first $40,000; TransAmerica, shall bear [*]% and the MCO shall bear [*]% of the amount that exceeds $40,000.

Stop-loss/reinsurance provisions are normally based on services provided within the contract period ending June 30. However, for purposes of this stop-loss/reinsurance provision the Contract period is extended for transplantations performed between April 1, 2000 and June 30, 2000. When the transplantation is performed between April 1, 2000 and June 30, 2000 the payment for the first $40,000 of the transplantation costs and the costs that exceed $40,000 can be applied to this stop-loss/reinsurance provision for up to 90 days after the transplantation is performed.

E. REIMBURSEMENT FOR REINSURANCE

The CONTRACTOR agrees to purchase reinsurance from TransAmerica at the rate negotiated by the DEPARTMENT of $ [*] per Enrollee per month. The DEPARTMENT will reimburse the CONTRACTOR for their premium payments to TransAmerica.

In addition, the DEPARTMENT will pay the CONTRACTOR [*]% of the premium to cover reinsurance administrative costs.

1. INTERIM PAYMENTS

Beginning July 1, 1999, the DEPARTMENT will make monthly interim payments to the CONTRACTOR based on the reinsurance premiums the CONTRACTOR pays to Insurance Strategies, an agent of TransAmerica. The reinsurance premiums will be calculated using the previous month's number of Enrollees.

2. FINAL SETTLEMENT

The DEPARTMENT will calculate the actual reinsurance amount due to the CONTRACTOR one month after the end of each contract year. The settlement will be based on actual Enrollee months.

F. RISK SHARING PROVISION

The DEPARTMENT agrees to retroactively adjust annual payments made to the CONTRACTOR under this Contract for clients living in the rural counties of Box Elder, Cache, Iron, Kane, Washington, Garfield and Beauer.

1. CONTRACTOR'S CLAIM EXPENDITURES EXCEEDING PREMIUMS, ETC.

If the CONTRACTOR'S claim expenditures exceed the premiums paid plus other contract payments, the DEPARTMENT will reimburse the CONTRACTOR for the unrecovered costs related to claim expenditures. Claim contract payments include stop-loss payments. Therefore, the paid claims expenditures will also include stop-loss claims paid by the CONTRACTOR.

2. CONTRACTOR'S CLAIM EXPENDITURES LESS THAN PREMIUMS, ETC.

If the CONTRACTOR'S claim expenditures are less than the premiums paid plus other contract payments, the CONTRACTOR can retain up to [*]% of the excess premiums paid and other payments. If there are additional savings after the CONTRACTOR has recovered the 10%, the DEPARTMENT and CONTRACTOR will share these savings on a 50-50 basis. Claim contract payments include stop-loss payments. Therefore, the paid claims expenditures will also include stop-loss claims paid by the CONTRACTOR.

A request for a risk sharing adjustment shall be submitted to the DEPARTMENT no later than six months after the close of the contract year. The CONTRACTOR agrees to use its Medicaid payment rates and fee schedules used to price their Medicaid product as a basis for the risk sharing calculation.

UTAH DEPARTMENT OF HEALTH
288 North 1460 West, Salt Lake City, Utah 84116

CONTRACT AMENDMENT

H9920205-02	00-6146
Department Log Number	State Contract Number

1. CONTRACT NAME:
   The name of this Contract is HMO-AMERICAN FAMILY CARE, the Contract number assigned by the State Division of Finance is 006146, the Department log number assigned by the Utah Department of Health is H9920205, and this Amendment is number 2.

2. CONTRACTING PARTIES:
   This Contract Amendment is between the Utah Department of Health (DEPARTMENT), and American Family Care of Utah, Inc. (CONTRACTOR).

3. PURPOSE OF CONTRACT AMENDMENT:
   To modify some of the provisions under Attachments B, C, and E; to add provisions under Attachment B; and to increase the rates effective July 1, 2000.

4. CHANGES TO CONTRACT:
   A. Effective July 1, 2000, under Attachment B (Special Provisions), Article I - Definitions, item D. "CHEC Program," delete "(See Attachment C, Covered Services, 21.)."

   B. Effective July 1, 2000, under Attachment B (Special Provisions), Article IV - Benefits, Section C. Scope of Services, add Subsection "4" as follows:

      4. MEDICAL NECESSITY DENIALS

         When the CONTRACTOR determines that a service will not be covered due to the lack of medical necessity, the CONTRACTOR must send all documentation supporting their decision to the DEPARTMENT for its review before the CONTRACTOR's determination is deemed final, when the following conditions are met:

         a. there are no established national standards for determining medical necessity; and

         b. the DEPARTMENT does not have medical necessity criteria for the service.

         The DEPARTMENT will review the documentation and determine what the DEPARTMENT's decision would be regarding coverage for the service. The DEPARTMENT and the CONTRACTOR will work collaboratively in making a final decision on whether the service is to be covered by the CONTRACTOR.

   C. Effective July 1, 2000, under Attachment B (Special Provisions), Article IV-Benefits, Section E. Clarification of Covered Services, Subsection 1 Emergency Services, delete item "c."

   D. Effective July 1, 2000, under Attachment B (Special Provisions), Article V-Enrollee Rights/Services, Section F. Coordination, add Subsection "3" as follows:

      3. DOMESTIC VIOLENCE

         The CONTRACTOR will ensure that providers are knowledgeable about methods to detect domestic violence and about resources in the community to which they can refer patients.

   E. Effective July 1, 2000, under Attachment B (Special Provisions), Article VII - Other Requirements, Section C. Fraud and Abuse Requirements, add the following language:

      "The CONTRACTOR must have a compliance program to identify and refer suspected fraud and abuse activities. The compliance program should outline the CONTRACTOR's internal processes for identifying fraud and abuse."

F. Effective July 1, 2000, under Attachment B (Special Provisions), Article IX - Record, Reports and Audits, Section B. Periodic Reports, add Subsection 2. Interpretive Services as follows and renumber subsequent sections "3" through "9":

2. INTERPRETIVE SERVICES

Annually, the CONTRACTOR will submit to the DEPARTMENT information about the use of interpretive services as follows: all sources of interpreter services, the languages for which interpreter services were secured, the amount of time spent by language, the expenditures by language, the amount of time spent by clinical versus administrative purposes, and the expenditures by clinical versus administrative purposes.

G. Effective July 1, 2000, under Attachment B (Special Provisions), Article IX - Records, Reports and Audits, Section B. Periodic Reports, Subsection 5. Encounter Data, is changed to Subsection 6 and changed to read:

"Encounter data, as defined in the DEPARTMENT's "Encounter Records Technical Manual," is due (including all replacements) six months after the end of the quarter being reported. Encounter data will be submitted in accordance with the instructions detailed in the Encounter Records Technical Manual for dates of service beginning July 1, 1996."

H. Effective July 1, 2000, under Attachment C. Covered Services, Item Y. Medical and Surgical Services of a Dentist, number 3. Services Specifically Covered, is changed to read as follows:

3. SERVICES SPECIFICALLY COVERED

The CONTRACTOR is responsible for palliative care and pain relief for severe mouth or tooth pain in an emergency room. If the emergency room physician determines that it is not an emergency and the client requires services at a lesser level, the provider should refer the client to a dentist for treatment. If the dental-related problem is serious enough for the client to be admitted to the hospital, the CONTRACTOR is responsible for coverage of the inpatient hospital stay. The CONTRACTOR is responsible for authorized/ approved medical services provided by oral surgeons consistent with injury, accident, or disease (excluding dental decay and periodontal disease) including, but not limited to, removal of tumors in the mouth, setting and wiring a fractured jaw. Also covered are injuries to sound natural teeth and associated bone and tissue resulting from accidents including services by dentists performed in facilities other than the emergency room or hospital.

I. Effective July 1, 2000, under Attachment C. Covered Services, Item Y. Medical and Surgical Services of a Dentist, number 4. Dental Services Not Covered, is changed to read as follows:

4. DENTAL SERVICES NOT COVERED

The CONTRACTOR is not responsible for routine dental services such as fillings, extractions, treatment of abscess or infection, orthodontics, and pain relief when provided by a dentist in the office or in an outpatient setting such as a surgical center or scheduled same day surgery in a hospital including the surgical facilities charges.

J. Effective July 1, 2000, under Attachment E, replace Table 2 (Cost Data) with Table 2 (Cost Data) and MEDICAL SERVICES REVENUE AND COST DEFINITIONS FOR TABLE 2 as attached to this Amendment #1.

K. Effective July 1, 2000, replace Attachment F - Rates and Rate-Related Terms with Attachment F - Urban Rates and Rate-Related Terms, Effective July 1, 2000, as attached to this Amendment #2.

L. Effective July 1, 2000, replace Attachment F-1 Rural Rates and Rate-Related Terms with Attachment F-1 Rural Rates and Rate-Related Terms, Effective July 1, 2000, as attached to this Amendment #2.

M. All other provisions of the Contract remain unchanged.

5. If the Contractor is not a local public procurement unit as defined by the Utah Procurement Code (UCA Section 63-56-5), this Contract Amendment must be signed by a representative of the State Division of Finance and the State Division of Purchasing to bind the State and the Department to this Contract Amendment.

6. This Contract, its attachments, and all documents incorporated by reference constitute the entire agreement between the parties and supercede all prior negotiations, representations, or agreements, either written or oral between the parties relating to the subject matter of this Contract.

IN WITNESS WHEREOF, the parties sign this Contract Amendment.

CONTRACTOR: American Family Care of Utah, Inc.		UTAH DEPARTMENT OF HEALTH	
By: /s/ Kirk Olsen	5 September 2000	By: /s/ Shari A. Watkins	9/12/2000
Signature of Authorized Individual	Date	Shari A. Watkins, C.P.A. Director Office of Fiscal Operations	Date
Print Name: Kirk Olsen		[SEAL]	9/26/2000
		State Finance:	Date
Title: Chief Executive Officer			
		/s/ [ILLEGIBLE]	SEP 22 2000
33-0617992		State Purchasing	Date
Federal Tax Identification Number or Social Security Number			

1	2	3	4	5	6	7	8	9	10	11	12
LINE NO	MONTH	INFANTS 0-12 MOS	AFDC MALE * 21 YEARS ** 12 MOS	AFDC MALE 21 + YEARS	AFDC FEMALE * 21 YEARS **12 MOS	AFDC FEMALE 21 + YEARS	AGED	DISABLED MALE	DISABLED FEMALE	MED NEDDY CHILD	MED NEDDY OTHER
1	JULY										
2	AUGUST										
3	SEPTEMBER										
4	OCTOBER										
5	NOVEMBER										
6	DECEMBER										
7	JANUARY										
8	FEBRUARY										
9	MARCH										
10	APRIL										
11	MAY										
12	JUNE										
13	TOTAL	0	0	0	0	0	0	0	0	0	0

* less than
** greater than

1	2	13	14	15	16
LINE NO	MONTH	NON AFDC PREGNANT FEMALE (SOBRA)	RESTRICTION CLIENTS	AIDS	MEDICAID TOTAL (SUM OF COLS 3 THRU 15)
1	JULY				0
2	AUGUST				0
3	SEPTEMBER				0
4	OCTOBER				0
5	NOVEMBER				0
6	DECEMBER				0
7	JANUARY				0
8	FEBRUARY				0
9	MARCH				0
10	APRIL				0
11	MAY				0
12	JUNE				0
13	TOTAL	0	0	0	0

PROVIDER NAME: ____

SERVICE REPORTING PERIOD: BEGINNING____________ ENDING____________

PAYMENT DATES: BEGINNING____________ ENDING____________

ATTACHMENT E
TABLE 2 PAGE 1 OF 2
REVENUES AND COST

1	2	3	4	5	6	7	8
		--------MEDICAID (CAPITATED ONLY, NO FEE FOR SERVICE)--------					
LINE NO	DESCRIPTION	TOTAL UTAH OPERATIONS (INCLUDING ALL MEDICAID)	INFANTS 0-12 MOS	AFDC MALE * 21 YEARS ** 12 MOS	AFDC MALE 21 + YEARS	AFDC FEMALE * 21 YEARS ** 12 MOS	AFDC FEMALE 21 + YEARS
	REVENUES		ROUND TO THE NEAREST DOLLAR				
1	PREMIUMS						
2	DELIVERY FEES (CHILD BIRTH)						
3	REINSURANCE						
4	STOP LOSS						
5	TPL COLLECTIONS - MEDICARE						
6	TPL COLLECTIONS - OTHER						
7	OTHER (SPECIFY)						
8	OTHER (SPECIFY)						
9	TOTAL REVENUES	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0
	MEDICAL COSTS		ROUND TO THE NEAREST DOLLAR				
10	INPATIENT HOSPITAL SERVICES						
11	OUTPATIENT HOSPITAL SERVICES						
12	EMERGENCY DEPARTMENT SERVICES						
13	PRIMARY CARE PHYSICIAN SERVICES						
14	SPECIALTY CARE PHYSICIAN SERVICES						
15	ADULT SCREENING SERVICES						
16	VISION CARE - OPTOMETRIC SERVICES						
17	VISION CARE - OPTICAL SERVICES						
18	LABORATORY (PATHOLOGY) SERVICES						
19	RADIOLOGY SERVICES						
20	PHYSICAL AND OCCUPATIONAL THERAPY						
21	SPEECH AND HEARING SERVICES						
22	PODIATRY SERVICES END STAGE RENAL DISEASE						
23	(ESRD) SERVICES - DIALYSIS						
24	HOME HEALTH SERVICES						
25	HOSPICE SERVICES						
26	PRIVATE DUTY NURSING						
27	MEDICAL SUPPLIES AND MEDICAL EQUIPMENT						
28	ABORTIONS						
29	STERILIZATIONS						
30	DETOXIFICATION						
31	ORGAN TRANSPLANTS						
32	OTHER OUTSIDE MEDICAL SERVICES						
33	LONG TERM CARE						

LINE NO	DESCRIPTION						
34	TRANSPORTATION SERVICES						
35	ACCRUED COSTS						
36	OTHER (SPECIFY)						
37	OTHER (SPECIFY)						
38	TOTAL MEDICAL COSTS	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0

* less than
** greater than

--------------------MEDICAID (CAPITATED ONLY, NO FEE FOR SERVICE)---------------

1	2	9	10	11	12	13	14	15	16	17
LINE NO	DESCRIPTION	AGED	DISABLED MALE	DISABLED FEMALE	MED NEDDY CHILD	MED NEEDY OTHER	NON AFDC PREGNANT FEMALE (SOBRA)	RESTRICTION CLIENTS	AIDS	MEDICAID TOTAL (SUM OF COLS 4 THRU 16)
	REVENUES			ROUND TO THE NEAREST DOLLAR						
1	PREMIUMS									
2	DELIVERY FEES (CHILD BIRTH)									
3	REINSURANCE									
4	STOP LOSS									
5	TPL COLLECTIONS - MEDICARE									
6	TPL COLLECTIONS - OTHER									
7	OTHER (SPECIFY)									
8	OTHER (SPECIFY)									
9	TOTAL REVENUES	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0
	MEDICAL COSTS			ROUND TO THE NEAREST DOLLAR						
10	INPATIENT HOSPITAL SERVICES									
11	OUTPATIENT HOSPITAL SERVICES									
12	EMERGENCY DEPARTMENT SERVICE									
13	PRIMARY CARE PHYSICIAN SERVICES									
14	SPECIALTY CARE PHYSICIAN SERVICES									
15	ADULT SCREENING SERVICES									
16	VISION CARE - OPTOMETRIC SERVICES									
17	VISION CARE - OPTICAL SERVICES									
18	LABORATORY (PATHOLOGY) SERVICES									
19	RADIOLOGY SERVICES									
20	PHYSICAL AND OCCUPATIONAL THERAPY									
21	SPEECH AND HEARING SERVICES									
22	PODIATRY SERVICES END STAGE RENAL DISEASE									
23	(ESRD) SERVICES - DIALYSIS									
24	HOME HEALTH SERVICES									
25	HOSPICE SERVICES									
26	PRIVATE DUTY NURSING									
27	MEDICAL SUPPLIES AND MEDICAL EQUIPMENT									
28	ABORTIONS									
29	STERILIZATIONS									
30	DETOXIFICATION									
31	ORGAN TRANSPLANTS									
32	OTHER OUTSIDE MEDICAL									

	SERVICES									
33	LONG TERM CARE									
34	TRANSPORTATION SERVICES									
35	ACCRUED COSTS									
36	OTHER (SPECIFY)									
37	OTHER (SPECIFY)									
38	TOTAL MEDICAL COSTS	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0

1	2	3	4	5	6	7	8
		MEDICAID (CAPITATED ONLY, NO FEE FOR SERVICE)					
LINE NO	DESCRIPTION	TOTAL UTAH OPERATIONS (INCLUDING ALL MEDICAID)	INFANTS 0-12 MOS	AFDC MALE * 21 YEARS ** 12 MOS	AFDC MALE 21 + YEARS	AFDC FEMALE * 21 YEARS ** 12 MOS	AFDC FEMALE 21 + YEARS
	ADMINISTRATIVE COSTS			ROUND TO THE NEAREST DOLLAR			
39	ADMINISTRATION - ADVERTISING						
40	HOME OFFICE INDIRECT COST ALLOCATIONS						
41	UTILIZATION						
42	ADMINISTRATION - OTHER						
43	TOTAL ADMINISTRATIVE COSTS	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0
44	TOTAL COSTS (MED & ADMIN)	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0
45	NET INCOME [Gain or (Loss)]	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0
46	ENROLLEE MONTHS		0	0	0	0	0
47	MEDICAL COST @ ENROLLEE MO						
48	ADMIN COST @ ENROLLEE MO						
49	TOTAL COST @ ENROLLEE MO						
	OTHER DATA						
50	TPL SAVINGS COST AVOIDANCE"						
51	DUPLICATE PREMIUMS ***						
52	NUMBER OF DELIVERIES ****						
53	FAMILY PLANNING SERVICES						
54	REINSURANCE PREMIUMS RECEIVED						
55	REINSURANCE PREMIUMS PAID						
56	ADMINISTRATIVE REVENUE RETAINED BY THE CONTRACTOR						

* less than
** greater than

1	2	9	10	11	12	13	14
		MEDICAID (CAPITATED ONLY, NO FEE FOR SERVICE)					
LINE NO	DESCRIPTION	AGED	DISABLED MALE	DISABLED FEMALE	MED NEDDY CHILD	MED NEDDY OTHER	NON AFDC PREGNANT FEMALE (SOBRA)
	ADMINISTRATIVE COSTS			ROUND TO THE NEAREST DOLLAR			
39	ADMINISTRATION -ADVERTISING						
40	HOME OFFICE INDIRECT COST ALLOCATIONS						
41	UTILIZATION						
42	ADMINISTRATION - OTHER						
43	TOTAL ADMINISTRATIVE COSTS	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0
44	TOTAL COSTS (MED & ADMIN)	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0
45	NET INCOME [Gain or (Loss)]	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0

LINE NO	DESCRIPTION						
46	ENROLLEE MONTHS	0	0	0	0	0	0
47	MEDICAL COST @ ENROLLEE MO						
48	ADMIN COST @ ENROLLEE MO						
49	TOTAL COST @ ENROLLEE MO						
	OTHER DATA						
50	TPL SAVINGS COST AVOIDANCE **						
51	DUPLICATE PREMIUMS ***						
52	NUMBER OF DELIVERIES ****						
53	FAMILY PLANNING SERVICES						
54	REINSURANCE PREMIUMS RECEIVED						
55	REINSURANCE PREMIUMS PAID						
56	ADMINISTRATIVE REVENUE RETAINED BY THE CONTRACTOR						

-MEDICAID (CAPITATED ONLY, NO FEE FOR SERVICE)-

1	2	15	16	17
LINE NO	DESCRIPTION	RESTRICTION CLIENTS	AIDS	MEDICAID TOTAL (SUM OF COLS 4 THRU 16)
	ADMINISTRATIVE COSTS	ROUND TO THE NEAREST DOLLAR		
39	ADMINISTRATION -ADVERTISING			
40	HOME OFFICE INDIRECT COST ALLOCATIONS			
41	UTILIZATION			
42	ADMINISTRATION - OTHER			
43	TOTAL ADMINISTRATIVE COSTS	$ 0	$ 0	$ 0
44	TOTAL COSTS (MED & ADMIN)	$ 0	$ 0	$ 0
45	NET INCOME [Gain or (Loss)]	$ 0	$ 0	$ 0
46	ENROLLEE MONTHS	0	0	0
47	MEDICAL COST @ ENROLLEE MO			
48	ADMIN COST @ ENROLLEE MO			
49	TOTAL COST @ ENROLLEE MO			
	OTHER DATA			
50	TPL SAVINGS o COST AVOIDANCE"			$ 0
51	DUPLICATE PREMIUMS ***			$ 0
52	NUMBER OF DELIVERIES ****			0
53	FAMILY PLANNING SERVICES			$ 0
54	REINSURANCE PREMIUMS RECEIVED			$ 0
55	REINSURANCE PREMIUMS PAID			$ 0
56	ADMINISTRATIVE REVENUE RETAINED BY THE CONTRACTOR			$ 0

** COST OF SERVICES PROVIDED TO HMO CLIENTS. NOT PAID FOR BY HMO, E.G. "AVOIDED", BECAUSE OTHER INSURANCE PAID FOR IT.

*** CASH AMOUNT RETURNED TO MEDICAID BY HMO BECAUSE HMO CLIENT WAS COVERED IN THE SAME HMO BY ANOTHER CARRIER.

**** NUMBER OF CHILDREN DELIVERED. THIS NUMBER TIMES RATES SHOULD EQUAL DELIVERY REVENUE.

In this Medicaid portion, include only costs for Medicaid clients under the capitation agreement - exclude revenue, costs & TPL categories per this form that do not apply to your organization or contract.

MEDICAL SERVICES REVENUE AND COST DEFINITIONS FOR TABLE 2

REVENUES (Report all revenues received or receivable at the end-of-period date on the form)

1. Premiums

   Report premium payments received or receivable from the DEPARTMENT.

2. Delivery Fees

   Report the delivery fee received or receivable from the DEPARTMENT.

3. Reinsurance

   Report the reinsurance payments received or receivable from the REINSURANCE CARRIER (See Attachment F, Section D, Items 1 and 2).

4. Stop Loss

   Report stop loss payments received or receivable from the DEPARTMENT (See Attachment F, Section D, Item 2).

5. TPL Collections - Medicare

   Report all third party collections received from Medicare.

6. TPL Collections - Other

   Report all third party collections received other than Medicare collections. (Report TPL savings because of cost avoidance as a memo amount on line 48).

7. Other (specify)

8. Other (specify)

   For lines seven and eight: Report all other revenue not included in lines one through six. (There may not be any amount to report; however, this line can be used to report revenue from total Utah operations that do not fit lines one through six.)

9. TOTAL REVENUES

   Total lines one through eight.

NOTE: Duplicate premiums are not considered a cost or revenue as they are collected by the CONTRACTOR and paid to the DEPARTMENT. Therefore, the payment to the DEPARTMENT would reduce or offset the revenue recorded when the duplicate premium was received. However, line 49 has been established for reporting duplicate premiums as a memo amount.

MEDICAL COSTS: Report all costs accrued as of the ending date on the form. In the first data column (column 3), report all costs for Utah operations per the general ledger. In the 14 Medicaid data columns (columns 4 through 17), report only costs for Medicaid Enrollees.

10. Inpatient Hospital Services

    Costs incurred in providing inpatient hospital services to Enrollees confined to a hospital.

11. Outpatient Hospital Services

    Costs incurred in providing outpatient hospital services to Enrollees, not including services provided in the emergency department.

12. Emergency Department Services

    Costs incurred in providing outpatient hospital emergency room services to Enrollees.

13. Primary Care Physician Services (Including EPSDT Services, Prenatal Care, and Family Planning Services)

    All costs incurred for Enrollees as a result of providing primary care physician, osteopath, physician assistant, nurse practitioner, and nurse midwife services, including payroll expenses, any capitation and/or contract payments, fee-for-service payments, fringe benefits, travel and office supplies.

14. Specialty Care Physician Services (Including EPSDT Services, Prenatal Care, and Family Planning Services)

    All costs incurred as a result of providing specialty care physician, osteopath, physician assistant, nurse practitioner, and nurse midwife services to Enrollees, including payroll expenses, any capitation and/or contract payments, fee-for-service payments, fringe benefits, travel and office supplies.

15. Adult Screening Services

    Expenses associated with providing screening services to Enrollees.

16. Vision Care - Optometric Services

    Included are payroll costs, any capitation and/or contract payments, and fee-for-service payments for services and procedures performed by an optometrist and other non-payroll expenses directly related to providing optometric services for Enrollees.

17. Vision Care - Optical Services

    Included are payroll costs, any capitation and/or contract payments and fee-for-service payments for services and procedures performed by an optician and other supportive staff, cost of eyeglass frames and lenses and other non-payroll expenses directly related to providing optical services for Enrollees.

18. Laboratory (Pathology) Services

Costs incurred as a result of providing pathological tests or services to Enrollees including payroll expenses, any capitation and/or contract payments, fee-for-service payments and other expenses directly related to in-house laboratory services. Excluded are costs associated with a hospital visit.

19. Radiology Services

Cost incurred in providing x-ray services to Enrollees, including x-ray payroll expenses, any capitation and/or contract payments, fee-for-service payments, and occupancy overhead costs. Excluded are costs associated with a hospital visit.

20. Physical and Occupational Therapy

Included are payroll costs, any capitation and/or contract payments, fee-for-service costs, and other non-payroll expenditures directly related to providing physical and occupational therapy services.

21. Speech and Hearing Services

Payroll costs, any capitation and/or contract payments, fee-for-service payments, and non-payroll costs directly related to providing speech and hearing services for Enrollees.

22. Podiatry Services

Salary expenses or outside claims, capitation and/or contract payments, fee-for-service payments, and non-payroll costs directly related to providing services rendered by a podiatrist to Enrollees.

23. End Stage Renal Disease (ESRD) Services - Dialysis

Costs incurred in providing renal dialysis (ESRD) services to Enrollees.

24. Home Health Services

Included are payroll costs, any capitation and/or contract payments, fee-for-service payments, and other non-payroll expenses directly related to providing home health services for Enrollees.

25. Hospice Services

Expenses related to hospice care for Enrollees including home care, general inpatient care for Enrollees suffering terminal illness and inpatient respite care for caregivers of Enrollees suffering terminal illness.

26. Private Duty Nursing

Expenses associated with private duty nursing for Enrollees.

27. Medical Supplies and Medical Equipment

This cost center contains fee-for-service cost for outside acquisition of medical requisites, special appliances as prescribed by the CONTRACTOR to Enrollees.

28. Abortions

Medical and hospital costs incurred in providing abortions for Enrollees.

29. Sterilizations

Medical and hospital costs incurred in providing sterilizations for Enrollees.

30. Detoxification

Medical and hospital costs incurred in providing treatment for substance abuse and dependency (detoxification) for Enrollees.

31. Organ Transplants

Medical and hospital costs incurred in providing transplants for Enrollees.

32. Other Outside Medical Services

The costs for specialized testing and outpatient surgical centers for Enrollees ordered by the CONTRACTOR.

33. Long Term Care

Costs incurred in providing long-term care for Enrollees required under Attachment C.

34. Transportation Services

Costs incurred in providing ambulance (ground and air) services for Enrollees.

35. Accrued Costs

Costs Incurred for services rendered to Enrollees but not yet billed.

36 & 37. Other

Report costs not otherwise reported.

38. TOTAL MEDICAL COSTS

Total lines 10 through 38.

ADMINISTRATIVE COSTS

Report payroll costs, any capitation and/or contract payments, non-payroll costs and occupancy overhead costs for accounting services, claims processing services, health plan services, data processing services, purchasing, personnel, Medicaid marketing and regional administration.

Report the administration cost under four categories - advertising, home office indirect cost allocation, utilization and all other administrative costs. If there are no advertising costs or indirect home office cost allocations, report a zero amount in the applicable lines.

39. Administration - Advertising

40. Home Office Indirect Cost Allocations

41. Utilization

    Payroll cost and any capitation and/or contract payments for utilization staff and other non-payroll costs directly associated with controlling and monitoring outside physician referral and hospital admission and discharges of Enrollees.

42. Administration - Other

43. TOTAL ADMINISTRATIVE COSTS

    Total lines 39 through 43.

44. TOTAL COSTS (MEDICAL AND ADMINISTRATIVE)

    Total lines 38 and 44.

45. NET INCOME (GAIN OR LOSS)

    Line 9 minus line 44.

46. ENROLLEE MONTHS

    Total Enrollee months for period of time being reported.

47. MEDICAL COSTS PER ENROLLEE MONTH

    Line 38 divided by line 46.

48. ADMINISTRATIVE COSTS PER ENROLLEE MONTH

    Line 43 divided by line 46.

49. TOTAL COSTS PER ENROLLEE MONTH

    Line 44 divided by line 46.

OTHER DATA

50. TPL Savings - Cost Avoidance

51. Duplicate Premiums

Include all premiums received for Enrollees from all sources other than Medicaid.

52. Number of Deliveries

Total number of Enrollee deliveries when the delivery occurred at 24 weeks or later.

53. Family Planning Services

Include costs associated with family planning services as defined in Attachment C (Covered Services, Section V, Family Planning Services).

54. Reinsurance Premiums Received

Include the reinsurance premiums received or receivable from the DEPARTMENT.

55. Reinsurance Premiums Paid

Include reinsurance premiums paid to the REINSURANCE CARRIER.

56. Administrative Revenue Retained by the CONTRACTOR

Include the administrative revenue retained by the CONTRACTOR from the reinsurance premiums received or receivable from the DEPARTMENT.

		MEDICAID (CAPITATED ONLY, NO FEE FOR SERVICE)					
1	2	3	4	5	6	7	8
LINE NO	SERVICE DESCRIPTION (REFER TO THE UNIT FOR SERVICE DEFINITIONS IN THE INSTRUCTIONS	INFANTS 0-12 MOS	AFDC MALE * 21 YEARS ** 12 MOS	AFDC MALE 21 + YEARS	AFDC FEMALE * 21 YEARS ** 12 MOS	AFDC FEMALE 21 + YEARS	AGED
1	HOSPITAL SERVICES - GENERAL DAYS						
2	HOSPITAL SERVICES - DISCHARGES						
3	HOSPITAL SERVICES - OUTPATIENT VISITS						
4	EMERGENCY DEPARTMENT VISITS						
5	PRIMARY CARE PHYSICIAN SERVICES						
6	SPECIALTY CARE PHYSICIAN SERVICES						
7	ADULT SCREENING SERVICES						
8	VISION CARE - OPTOMETRIC SERVICES						
9	VISION CARE - OPTICAL SERVICES						
10	LABORATORY (PATHOLOGY) PROCEDURES						
11	RADIOLOGY PROCEDURES						
12	PHYSICAL AND OCCUPATIONAL THERAPY SERVICES						
13	SPEECH AND HEARING SERVICES						
14	PODIATRY SERVICES						
15	END STAGE RENAL DISEASE(ESRD) SERVICES - DIALYSIS						
16	HOME HEALTH SERVICES						
17	HOSPICE DAYS						
18	PRIVATE DUTY NURSING SERVICES						
19	MEDICAL SUPPLIES AND MEDICAL SERVICES						
20	ABORTIONS PROCEDURES						
21	STERILIZATION PROCEDURES						
22	DETOXIFICATION DAYS						
23	ORGAN TRANSPLANTS						
24	OTHER OUTSIDE MEDICAL SERVICES						
25	LONG TERM CARE FACILITY DAYS						
26	TRANSPORTATION TRIPS						
27	OTHER (SPECIFY)						

* less than
** greater than

		MEDICAID (CAPITATED ONLY, NO FEE FOR SERVICE)					
1	2	9	10	11	12	13	14
	SERVICE						

LINE NO	DESCRIPTION (REFER TO THE UNIT FOR SERVICE DEFINITIONS IN THE INSTRUCTIONS	DISABLED MALE	DISABLED FEMALE	MED NEEDY CHILD	MED NEEDY OTHER	NON AFDC PREGNANT FEMALE (SOBRA)	RESTRICTION CLIENTS
1	HOSPITAL SERVICES - GENERAL DAYS						
2	HOSPITAL SERVICES - DISCHARGES						
3	HOSPITAL SERVICES - OUTPATIENT VISITS						
4	EMERGENCY DEPARTMENT VISITS						
5	PRIMARY CARE PHYSICIAN SERVICES						
6	SPECIALTY CARE PHYSICIAN SERVICES						
7	ADULT SCREENING SERVICES						
8	VISION CARE - OPTOMETRIC SERVICES						
9	VISION CARE - OPTICAL SERVICES						
10	LABORATORY (PATHOLOGY) PROCEDURES						
11	RADIOLOGY PROCEDURES						
12	PHYSICAL AND OCCUPATIONAL THERAPY SERVICES						
13	SPEECH AND HEARING SERVICES						
14	PODIATRY SERVICES						
15	END STAGE RENAL DISEASE(ESRD) SERVICES - DIALYSIS						
16	HOME HEALTH SERVICES						
17	HOSPICE DAYS						
18	PRIVATE DUTY NURSING SERVICES						
19	MEDICAL SUPPLIES AND MEDICAL SERVICES						
20	ABORTIONS PROCEDURES						
21	STERILIZATION PROCEDURES						
22	DETOXIFICATION DAYS						
23	ORGAN TRANSPLANTS						
24	OTHER OUTSIDE MEDICAL SERVICES						
25	LONG TERM CARE FACILITY DAYS						
26	TRANSPORTATION TRIPS						
27	OTHER (SPECIFY)						

--MEDICAID (CAPITATED ONLY, NO FEE FOR SERVICE)--

1	2	15	16
LINE NO	SERVICE DESCRIPTION (REFER TO THE UNIT OF SERVICE DEFINITIONS IN THE INSTRUCTIONS	AIDS	MEDICAID TOTAL (SUM OF COLS 3 THRU 15)
1	HOSPITAL SERVICES - GENERAL DAYS		0
2	HOSPITAL SERVICES - DISCHARGES		0
3	HOSPITAL SERVICES - OUTPATIENT VISITS		0
4	EMERGENCY DEPARTMENT VISITS		0
5	PRIMARY CARE PHYSICIAN SERVICES		0

6	SPECIALTY CARE PHYSICIAN SERVICES	0
7	ADULT SCREENING SERVICES	0
8	VISION CARE - OPTOMETRIC SERVICES	0
9	VISION CARE - OPTICAL SERVICES	0
10	LABORATORY (PATHOLOGY) PROCEDURES	0
11	RADIOLOGY PROCEDURES	0
12	PHYSICAL AND OCCUPATIONAL THERAPY SERVICES	0
13	SPEECH AND HEARING SERVICES	0
14	PODIATRY SERVICES	0
15	END STAGE RENAL DISEASE(ESRD) SERVICES - DIALYSIS	0
16	HOME HEALTH SERVICES	0
17	HOSPICE DAYS	0
18	PRIVATE DUTY NURSING SERVICES	0
19	MEDICAL SUPPLIES AND MEDICAL SERVICES	0
20	ABORTIONS PROCEDURES	0
21	STERILIZATION PROCEDURES	0
22	DETOXIFICATION DAYS	0
23	ORGAN TRANSPLANTS	0
24	OTHER OUTSIDE MEDICAL SERVICES	0
25	LONG TERM CARE FACILITY DAYS	0
26	TRANSPORTATION TRIPS	0
27	OTHER (SPECIFY)	0

NOTE: MEDICAL REQUISITIONS HAS BEEN DITCHED!!

MEDICAL SERVICES UTILIZATION DEFINITIONS FOR TABLE 3

MEDICAL SERVICES

1. Hospital Services - General Days

   Record total number of inpatient hospital days associated with inpatient medical care.

2. Hospital Services - Discharges

   Record total number of inpatient hospital discharges.

3. Hospital Services - Outpatient Visits

   Record total number of outpatient visits.

4. Emergency Department Visits

   Record total number of emergency room visits

5. Primary Care Physician Services

   Number of services and procedures defined by CPT-4 codes provided by primary care physicians or licensed physician extenders or assistants under direct supervision of a physician inclusive of all services except radiology, laboratory and injections/immunizations which should be reported in their appropriate section. The reporting of data under this category includes both outpatient and inpatient services.

6. Specialty Care Physician Services

   Number of services and procedures defined by CPT-4 codes provided by specialty care physicians or licensed physician extenders or assistants under direct supervision of a physician inclusive of all services except radiology, laboratory and injections/immunizations which should be reported in their appropriate section. The reporting of data under this category includes both outpatient and inpatient services.

7. Adult Screening Services

   Number of adult screenings performed.

8. Vision Care - Optometric Services

   Number of optometric services and procedures performed by an optometrist.

9. Vision Care - Optical Services

   Number of eye glasses and contact lenses dispensed.

10. Laboratory (Pathology) Procedures

    Number of procedures defined by CPT-4 Codes under the Pathology and Laboratory section. Excluded are services performed in conjunction with a hospital outpatient or emergency department visit.

11. Radiology Procedures

    Number of procedures defined by CPT-4 Codes under the Radiology section. Excluded are services performed in conjunction with a hospital outpatient or emergency department visit.

12. Physical and Occupational Therapy Services

    Physical therapy refers to physical and occupational therapy services and procedures performed by a physician or physical therapist.

13. Speech and Hearing Services

    Number of services and procedures.

14. Podiatry Services

    Number of services and procedures.

15. End Stage Renal Disease (ESRD) Services - Dialysis

    Number of ESRD procedures provided upon referral.

16. Home Health Services

    Number of home health visits, such as skilled nursing, home health aide, and personal care aide visits.

17. Hospice Days

    Number of days hospice care is provided, including respite care.

18. Private Duty Nursing Services

    Hours of skilled care delivered.

19. Medical Supplies and Medical Equipment

    Durable medical equipment such as wheelchairs, hearing aids, etc., and nondurable supplies such as oxygen etc.

20. Abortion Procedures

    Number of procedures performed.

21. Sterilization Procedures

    Number of procedures performed.

22. Detoxification Days

    Days of inpatient detoxification.

23. Organ Transplants

    Number of transplants.

24. Other Outside Medical Services

    Specialized testing and outpatient surgical services ordered by IHC.

25. Long Term Care Facility Days

    Total days associated with long-term care.

26. Transportation Trips

    Number of ambulance trips.

27. Other (specify)

ATTACHMENT E
TABLE 4 PAGE 1 OF 1
MEDICAID MALPRACTICE INFORMATION

PROVIDER NAME: ____

SERVICE REPORTING PERIOD: BEGINNING __________ ENDING ________________________

ORGANIZATIONS NAMED IN THE MALPRACTICE CLAIM:

CLAIM NUMBER 1 ____

CLAIM NUMBER 2 ____

CLAIM NUMBER 3 ____

MEDICAL PROFESSIONALS SPECIFIED:

CLAIM NUMBER 1 ____

CLAIM NUMBER 2 ____

CLAIM NUMBER 3 ____

LOCATIONS WHERE CLAIMS ORIGINATED:

CLAIM NUMBER 1 ____

CLAIM NUMBER 2 ____

CLAIM NUMBER 3 ____

MEDICAID CLIENT IDENTIFICATION:

CLAIM NUMBER 1 ____

CLAIM NUMBER 2 ____

CLAIM NUMBER 3 ____

DATES OF SERVICE:

CLAIM NUMBER 1 ____

CLAIM NUMBER 2 ____

CLAIM NUMBER 3 ____

AWARDS TO MEDICAID CLIENTS - AMOUNTS & DATES PAID

CLAIM NUMBER 1 ____

CLAIM NUMBER 2 ____

CLAIM NUMBER 3 ____

HMO'S DIRECT COSTS (IF ANY)

CLAIM NUMBER 1 ____

CLAIM NUMBER 2 ____

CLAIM NUMBER 3 ____

ATTACH A SUMMARY OF FACTS FOR EACH CASE, DESCRIBING THE CLAIM, THE CAUSES, CIRCUMSTANCES, ETC.

The information reported on this form should come from known malpractice cases of the MCO providers. This may only be applicable if the MCO was named as a participant in the malpractice suit. However, if suits against MCO providers are known, provide us with information on the Medicaid client(s) involved and any large settlements paid when the information is available.

ATTACHMENT F - URBAN RATES AND RATE-RELATED TERMS

Effective July 1, 2000

AMERICAN FAMILY CARE OF UTAH, INC.

A. PREMIUM RATES

1. MONTHLY PREMIUM RATES BASED ON ENROLLEES' RATE CELLS

Age 0 to 1	TANF Male 1 to 21	TANF Male 21 & Over	TANF Female 1 to 21	TANF Female 21 & Over	Aged
$ [*]	$ [*]	$ [*]	$ [*]	$ [*]	$ [*]

Disabled Male	Disabled Female	Medically Needy Child	Medically Needy Adult	Non TANF Pregnant F	Restriction Program
$ [*]	$ [*]	$ [*]	$ [*]	$ [*]	$ [*]

2. SPECIAL RATE

An AIDS rate of $ [*] per month will be paid in addition to the regular monthly premium when the T-Cell count is below 200.

B. PER DELIVERY REIMBURSEMENT SCHEDULE

The DEPARTMENT shall reimburse the CONTRACTOR $ [*] per delivery to cover all Medically Necessary antepartum care, delivery, and postpartum professional, facility and ancillary services. The monthly premium amount for the enrollee is in addition to the delivery fee. The delivery payment will be made when the delivery occurs at 22 weeks or later, regardless of viability.

C. CHEC SCREENING INCENTIVE CLAUSE

1. CHEC Screening Goal

The CONTRACTOR will ensure that Medicaid children have access to appropriate well- child visits. The CONTRACTOR will follow the Utah EPSDT (CHEC) guidelines for the periodicity schedule for well-child protocol. The federal agency, Health Care Financing Administration, mandates that all states have 80% of all children screened. The DEPARTMENT and the CONTRACTOR will work toward that goal.

2. Calculation of CHEC Incentive Payment

The DEPARTMENT will pay the CONTRACTOR $ [*] for each percentage point over 60% achieved by the CONTRACTOR. The DEPARTMENT will calculate the CONTRACTOR'S annual participation rate based on information supplied by the CONTRACTOR under the EPSDT (CHEC) reporting requirements at the same time each federal fiscal year's HCFA-416 is calculated. Payment will be based on the percentages determined at that time.

3. CONTRACTOR's Use of Incentive Payment

The CONTRACTOR agrees to use this incentive payment to reward the CONTRACTOR's employees responsible for improving the EPSDT (CHEC) participation rate.

D. REINSURANCE POLICY

Reinsurance will be administered by a reinsurer, Zurich Insurance.

Costs, net of TPL, for all inpatient and outpatient services listed in Attachment C that are covered on the date of service rendered and incurred from July 1, 2000 through June 30, 2001 by the CONTRACTOR for an Enrollee shall be shared by Zurich Insurance under the following conditions:

1. the date of service is from July 1, 2000 through June 30, 2001 (based on the date of discharge if inpatient hospital stay);

2. paid claims incurred by the CONTRACTOR exceed $50,000.00; and

3. services shall have been incurred by the CONTRACTOR during the time the client is enrolled with the CONTRACTOR.

If the above conditions are met, Zurich Insurance shall bear [*]% and the CONTRACTOR shall bear [*]% of the amount that exceeds $50,000.00.

E. REIMBURSEMENT FOR REINSURANCE

The CONTRACTOR agrees to purchase reinsurance from Zurich Insurance at the rate negotiated by the DEPARTMENT of $ [*] per Enrollee per month. The DEPARTMENT will reimburse the CONTRACTOR for their premium payments to Zurich Insurance. In addition, the DEPARTMENT will pay the CONTRACTOR $ [*] to cover reinsurance administrative costs.

Beginning July 1, 2000, the DEPARTMENT will make monthly payments to the CONTRACTOR based on the reinsurance premiums the CONTRACTOR pays to Zurich Insurance. The DEPARTMENT will calculate the reinsurance premiums using the DEPARTMENT's data on the number of Enrollees.

ATTACHMENT F-1 - RURAL RATES AND RATE-RELATED TERMS

Effective July 1, 2000

AMERICAN FAMILY CARE OF UTAH, INC.

A. PREMIUM RATES

1. MONTHLY PREMIUM RATES BASED ON ENROLLEES' RATE CELLS

Age 0 to 1	TANF Male 1 to 21	TANF Male 21 & Over	TANF Female 1 to 21	TANF Female 21 & Over	Aged
$ [*]	$ [*]	$ [*]	$ [*]	$ [*]	$ [*]

Disabled Male	Disabled Female	Medically Needy Child	Medically Needy Adult	Non TANF Pregnant F	Restriction Program
$ [*]	$ [*]	$ [*]	$ [*]	$ [*]	$ [*]

2. SPECIAL RATE

An AIDS rate of $ [*] per month will be paid in addition to the regular monthly premium when the T-Cell count is below 200.

B. PER DELIVERY REIMBURSEMENT SCHEDULE

The DEPARTMENT shall reimburse the CONTRACTOR $ [*] per delivery to cover all Medically Necessary antepartum care, delivery, and postpartum professional, facility and ancillary services. The monthly premium amount for the enrollee is in addition to the delivery fee. The delivery payment will be made when the delivery occurs at 22 weeks or later, regardless of viability.

C. CHEC SCREENING INCENTIVE CLAUSE

1. CHEC SCREENING GOAL

The CONTRACTOR will ensure that Medicaid children have access to appropriate well- child visits. The CONTRACTOR will follow the Utah EPSDT (CHEC) guidelines for the periodicity schedule for well-child protocol. The federal agency, Health Care Financing Administration, mandates that all states have 80% of all children screened. The DEPARTMENT and the CONTRACTOR will work toward that goal.

2. CALCULATION OF CHEC INCENTIVE PAYMENT

The DEPARTMENT will pay the CONTRACTOR $ [*] for each percentage point over 60% achieved by the CONTRACTOR. The DEPARTMENT will calculate the CONTRACTOR's annual participation rate based on information supplied by the CONTRACTOR under the EPSDT (CHEC) reporting requirements at the same time each federal fiscal year's HCFA-416 is calculated. Payment will be based on the percentages determined at that time.

3. CONTRACTOR'S USE OF INCENTIVE PAYMENT

The CONTRACTOR agrees to use this incentive payment to reward the CONTRACTOR's employees responsible for improving the EPSDT (CHEC) participation rate.

D. REINSURANCE POLICY

Reinsurance will be administered by a reinsurer, Zurich Insurance.

Costs, net of TPL, for all inpatient and outpatient services listed in Attachment C that are covered on the date of service rendered and incurred from July 1, 2000 through June 30, 2001 by the CONTRACTOR for an Enrollee shall be shared by Zurich Insurance under the following conditions:

1. The date of service is from July 1, 2000 through June 30, 2001 (based on the date of discharge if inpatient hospital stay);

2. paid claims incurred by the CONTRACTOR exceed $50,000.00; and

3. services shall have been incurred by the CONTRACTOR during the time the client is enrolled with the CONTRACTOR.

If the above conditions are met, Zurich Insurance shall bear [*]% and the CONTRACTOR shall bear [*]% of the amount that exceeds $50,000.00.

E. REIMBURSEMENT FOR REINSURANCE

The CONTRACTOR agrees to purchase reinsurance from Zurich Insurance at the rate negotiated by the DEPARTMENT of $ [*] per Enrollee per month. The DEPARTMENT will reimburse the CONTRACTOR for their premium payments to Zurich Insurance. In addition, the DEPARTMENT will pay the CONTRACTOR $ [*] to cover reinsurance administrative costs.

Beginning July 1, 2000, the DEPARTMENT will make monthly payments to the CONTRACTOR based on the reinsurance premiums the CONTRACTOR pays to Zurich Insurance. The DEPARTMENT will calculate the reinsurance premiums using the DEPARTMENT's data on the number of Enrollees.

F. RISK SHARING PROVISION

The DEPARTMENT agrees to retroactively adjust annual payments made to the CONTRACTOR under this Contract for clients living in the rural counties served by the CONTRACTOR.

1. CONTRACTOR's CLAIM EXPENDITURES EXCEEDING PREMIUMS, ETC.

If the CONTRACTOR's claim expenditures exceed the premiums paid plus other Contract payments, the DEPARTMENT will reimburse the CONTRACTOR for the unrecovered costs related to claim expenditures. Claim contract payments include stop-loss payments. Therefore, the paid claims expenditures will also include stop-loss claims paid by the CONTRACTOR.

2. CONTRACTOR'S CLAIM EXPENDITURES LESS THAN PREMIUMS, ETC.

If the CONTRACTOR's claim expenditures are less than the premiums paid plus other Contract payments, the CONTRACTOR can retain up to [*]% of the excess premiums paid and other payments. If there are additional savings after the CONTRACTOR has recovered the [*]%, the DEPARTMENT and the CONTRACTOR will share these savings on a [*] basis. Claim contract payments include stop-loss payments. Therefore, the paid claims expenditures will also include stop-loss claims paid by the CONTRACTOR.

A request for a risk sharing adjustment shall be submitted to the DEPARTMENT no later than six months after the close of the Contract year. The CONTRACTOR agrees to use its Medicaid payment rates and fee schedules used to price their Medicaid product as a basis for the risk sharing calculation.

UTAH DEPARTMENT OF HEALTH
288 North 1460 West, Salt Lake City, Utah 84116
CONTRACT AMENDMENT

H992020205-03	00-6146
Department Log Number	State Contract Number

1. CONTRACT NAME:
   The name of this Contract is HMO-AFC/MOLINA, the Department log number assigned by the Utah Department of Health is H992020205, and this Amendment is number 3.

2. CONTRACTING PARTIES:
   This Contract Amendment is between the Utah Department of Health (DEPARTMENT), and Molina Healthcare of Utah (CONTRACTOR).

3. PURPOSE OF CONTRACT AMENDMENT:
   To change the names of the Contract and CONTRACTOR, clarify some of the Contract provisions, add provisions, and to change the rates and rate-related provisions effective July 1, 2001.

4. CHANGES TO CONTRACT:
   A. On Page 1, item #1, CONTRACT NAME is changed to read "HMO-AFC/MOLINA."

   B. On Page 1, item #2, CONTRACTOR is changed to read "Molina Healthcare of Utah."

   C. Effective July 1, 2001, replace Attachment B with Attachment B as attached to this Amendment #3.

   D. Effective July 1, 2001, replace Attachment F - Urban Rates and Rate-Related Terms and Attachment F-1 Rural Rates and Rate-Related Terms with Attachment F - Urban & Rural Rates and Rate-Related Terms as attached to this Amendment #3.

   E. All other provisions of the Contract remain unchanged.

5. If the Contractor is not a local public procurement unit as defined by the Utah Procurement Code (UCA Section 63-56-5), this Contract Amendment must be signed by a representative of the State Division of Finance and the State Division of Purchasing to bind the State and the Department to this Contract Amendment.

6. This Contract, its attachments, and all documents incorporated by reference constitute the entire agreement between the parties and supercede all prior negotiations, representations, or agreements, either written or oral between the parties relating to the subject matter of this Contract.

IN WITNESS WHEREOF, the parties sign this Contract Amendment.

CONTRACTOR: Molina Healthcare of Utah		UTAH DEPARTMENT OF HEALTH	
By: /s/ Kirk Olsen	30 Aug 2001	By: /s/ Shari A. Watkins	09/17/01
Signature of Authorized Individual	Date	Shari A. Watkins, C.P.A. Director Office of Fiscal Operations	Date
Print Name: Kirk Olsen			
Title: Chief Executive Officer		[SEAL]	10-12-01
		State Finance:	Date
33-0617992		[ILLEGIBLE]	
Federal Tax Identification Number or Social Security Number		State Purchasing:	Date

For the purpose of the Contract all article. section, and subsection headings in these Attachments B, C, and D are for convenience in referencing the provisions of the Contract. They are not enforceable as part of the text of the Contract and may not be used to interpret the meaning of the provisions that lie beneath them.

ATTACHMENT B - SPECIAL PROVISIONS
Effective July 1,2001

ARTICLE I - DEFINITIONS

For the purpose of the Contract:

A. "Advance Directives" means oral and written instructions about an individual's medical care, in the event the individual is unable to communicate. There are two types of Advance Directives: a living will and a medical power of attorney.

B. "Balance Bill" means the practice of billing patients for charges that exceed the amount that the MCO will pay.

C. "CHEC Eligible" means any Medicaid recipient under the age of 21 who is eligible to receive Early Periodic Screening Diagnostic and Treatment (EPSDT) services in accordance with 42 CFR Part 441, Subpart B.

D. "CHEC Program" or Child Health Evaluation and Care program is Utah's version of the federally mandated Early Periodic Screening, Diagnosis and Treatment (EPSDT) program as defined in 42 CFR Part 441, Subpart B. (See Attachment C, Covered Services, U.)

E. "Child with Special Health Care Needs" means a child under 21 who has or is at increased risk for chronic physical, developmental, behavioral, or emotional conditions and requires health and related services of a type or amount beyond that required by children generally, including a child who, consistent with 1932(a)(2)(A) of the Social Security Act, 42 U.S.C., Section 1396u-2(a)(2)(A):

(1) is blind or disabled or in a related population (eligible for SSI under title XVI of the Social Security Act);
(2) is in foster care or other out-of-home placement;
(3) is receiving foster care or adoption assistance; or
(4) is receiving services through a family-centered, community-based coordinated care system that receives grant funds described in section 501(a)(l)(D) of title V.

F. "Division of Health Care Financing" or "DHCF" means the division within the Department of Health responsible for the administration of the Utah Medicaid program.

G. "Emergency Services" means those services provided in a hospital, clinic, office, or other facility that is equipped to furnish the required care, after the sudden onset of 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 that the absence of immediate medical attention to result in:

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of a woman or her unborn child) in serious jeopardy;

2. Serious impairment to bodily functions; or

3. Serious dysfunction of any bodily organ or part.

H. "Enrollee" means any Medicaid eligible: (1) who, at the time of enrollment resides within the geographical limits of the CONTRACTOR's Service Area; (2) whose name appears on the DEPARTMENT's Eligibility Transmission as a new, reinstate, or retroactive Enrollee; and (3) who is accepted for enrollment by the CONTRACTOR according to the conditions set forth in this Contract excluding residents of the Utah State Hospital, Utah State Developmental Center, and long-term care facilities except as defined in Attachment C.

I. "Enrollees with Special Health Care Needs" means enrollees who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount beyond that required by adults and children generally.

J. "Enrollment Area" or "Service Area" means the counties enumerated in Article II.

K. "Family Member" means all Medicaid eligibles who are members of the same family living at home.

L. "Home and Community-Based Services" means services, not otherwise furnished under the State's Medicaid plan, that are furnished under a waiver of statutory requirements granted under the provisions of CFR Part 441, subpart G. These services cover an array of Home and Community-Based Services that are cost-effective and necessary for an individual to avoid institutionalization.

M. "Managed Care Organization" or "MCO" means an organization that meets the State Plan's definition of an HMO or prepaid health plan and which provides, either directly or through arrangement with other providers, comprehensive general medical services to Medicaid eligibles on a contractual prepayment basis.

N. "Marketing Material" means materials in all mediums, including member handbooks, brochures and leaflets, newspaper, magazine, radio, television, billboard and yellow pages advertisements, and presentation materials used by marketing representatives. It includes materials mailed to, distributed to, or aimed at Medicaid clients specifically, and any material that mentions "Medicaid," "Medicaid Assistance," or "Title XIX."

O. "Medically Necessary" means any medical service that (a) is reasonably calculated to prevent,

diagnose, or cure conditions in the Enrollee that endanger life, cause suffering or pain, cause deformity or malfunction, or threaten to cause a handicap, and (b) there is no equally effective course of treatment available or suitable for the Enrollee requesting the service which is more conservative or substantially less costly. Medical services will be of a quality that meets professionally recognized standards of health care, and will be substantiated by records including evidence of such medical necessity and quality. Those records will be made available to the DEPARTMENT upon request. For CHEC Enrollees, "Medically Necessary" means preventive screening services and other medical care, diagnostic services, treatment, and other measures necessary to correct or ameliorate defects and physical and mental illnesses and conditions, even if the services are not included in the Utah State Medicaid Plan.

P. "Member Services" means a method of assisting Enrollees in understanding CONTRACTOR policies and procedures, facilitating referrals to participating specialists, and assisting in the resolution of problems and member complaints. The purpose of Member Services is to improve access to services and promote Enrollee satisfaction.

Q. "Physician Incentive Plan" means any compensation between a contracting organization and a physician group that may directly or indirectly have the effect of reducing or limiting services provided with respect to Enrollees in the organization.

R. "Prepaid Mental Health Plan" means the mental health centers that contract with the DEPARTMENT to provide inpatient and outpatient mental health services to Medicaid clients living within each mental health center's jurisdiction.

S. "Primary Care Provider" or "PCP" means a health care provider the majority of whose practice is devoted to internal medicine, family/general practice or pediatrics. The MCO may allow other specialists to be PCPs, when appropriate. PCPs are responsible for delivering primary care services, coordinating and managing Enrollees' overall health and, authorizing referrals for other necessary care.

T. "Restriction Program" means the Federally mandated program (42 CFR 431.54(e)) for Medicaid clients who over-utilize Medicaid services. If the DEPARTMENT in conjunction with the CONTRACTOR finds that an Enrollee has utilized Medicaid services at a frequency or amount that is not Medically Necessary, as determined in accordance with utilization guidelines adopted by the DEPARTMENT, the DEPARTMENT may place the Enrollee under the Restriction Program for a reasonable period of time to obtain Medicaid services from designated providers only.

U. "State Plan" means the State Plan for organization and operation of the Medicaid program as defined pursuant to Section 1102 of the Social Security Act (42 U.S.C. 1302).

ARTICLE II - SERVICE AREA

The Service Area is limited to the urban counties of Cache, Davis, Iron, Salt Lake, Utah, Washington and Weber.

ARTICLE III - ENROLLMENT, ORIENTATION, MARKETING, AND DISENROLLMENT

A. ENROLLMENT PROCESS

1. ENROLLEE CHOICE

The DEPARTMENT will offer potential Enrollees a choice among all MCOs available in the Enrollment Area. The DEPARTMENT will inform potential Enrollees of Medicaid benefits. The Medicaid client's intent to enroll is established when the applicant selects The CONTRACTOR, either verbally or by signing a choice of health care delivery form or equivalent. This initiates the action to send an advance notification to the CONTRACTOR. Medicaid Enrollees made eligible for a retroactive period prior to the current month are not eligible for CONTRACTOR enrollment during the retroactive period.

2. PERIOD OF ENROLLMENT

Each Enrollee will be enrolled for the period of the Contract or the period of Medicaid eligibility or until such person disenrolls or is disenrolled, whichever is earlier. Until the DEPARTMENT notifies the CONTRACTOR that an Enrollee is no longer Medicaid eligible, the CONTRACTOR may assume that the Enrollee continues to be eligible. Each Enrollee will be automatically re-enrolled at the end of each month unless that Enrollee notifies the DEPARTMENT'S Health Program Representative of an intent not to re-enroll in the MCO prior to the benefit issuance date.

3. OPEN ENROLLMENT

The CONTRACTOR will have a continuous open enrollment period that meets the requirements of Section 1301(d) of the Public Health Service Act. The DEPARTMENT will certify, and the CONTRACTOR agrees to accept individuals who are eligible to be enrolled in the MCO under the provisions of this Contract:

a. in the order in which they apply; and

b. without restrictions unless authorized by the DEPARTMENT.

4. NO HEALTH SCREENING

The DEPARTMENT and the CONTRACTOR agree that no potential Enrollee will be pre-screened or selected by either party for enrollment on the basis of pre-existing health problems or on the basis of race, color, national origin, disability or age.

5. INDEPENDENT ENROLLMENT

Each Medicaid eligible can be enrolled or disenrolled in the MCO, independent of any other Family Member's enrollment or disenrollment.

6. REPRESENTATIVE POPULATION

The CONTRACTOR will service a population representative of the categories of eligibility within the area it serves.

7. ELIGIBILITY TRANSMISSION

a. IN GENERAL

Before the close of business of each day, the DEPARTMENT will provide to the CONTRACTOR an Eligibility Transmission which is an electronic file that includes individuals which the DEPARTMENT certifies as Medicaid eligible and who enrolled in the MCO. Eligibility transmissions include new Enrollees, reinstated Enrollees, retroactive Enrollees, deleted Enrollees and Enrollees whose eligibility information results in a change to a critical field. The Eligibility Transmission will be in accordance with the Utah Health Information Network (UHIN) standard. The DEPARTMENT represents and warrants to the CONTRACTOR that the appearance of an individual's name on the Eligibility Transmission, other than a deleted Enrollee, will be conclusive evidence for purposes of this Contract, that such person is enrolled in the program and qualifies for medical assistance under Medicaid Title XIX and that the DEPARTMENT agrees to pay premiums for such Enrollees.

b. NEW ENROLLEES

New Enrollees are enrolled in this MCO until otherwise specified; these Enrollees will not appear on future transmissions unless there is a change in a critical field. Critical fields are coverage dates, recipient name, date of birth, date of death, sex, social security number, case information, address, telephone number, payment code, coordination of benefits, and the Enrollee's provider under the Restriction Program. Enrollees with a spenddown requirement will appear on the eligibility transmission on a month by month basis after the spenddown is met.

c. RETROACTIVE ENROLLEES

Retroactive Enrollees are those who were Enrollees previous to the current month. Retroactive Enrollees include newborn Enrollees or Enrollees who have been reported in one payment category in a previous month but have been changed to a new payment category for that previous month.

d. REINSTATED ENROLLEES

Reinstated Enrollees are those who were enrolled for the previous month and also closed at the end of the previous month. These Enrollees are eligible retroactively to the beginning of the current month.

e. DELETED ENROLLEES

Deleted Enrollees are those who are no longer eligible for Medicaid or who were disenrolled from the MCO.

f. ADVANCED NOTIFICATION TRANSMISSION

An Advanced Notification Transmission is another electronic file (separate from the Eligibility Transmission) that will be sent to the CONTRACTOR when an individual has selected the MCO prior to becoming eligible for Medicaid. These individuals may or may not become eligible for Medicaid. Use of information about such individuals is restricted to providing the individual with an orientation to the MCO prior to the individual's eligibility for Medicaid. The CONTRACTOR is not required to orient individuals until they appear on the Eligibility Transmission.

8. CHANGE OF ENROLLMENT PROCEDURES

The CONTRACTOR will be advised of anticipated changes in DEPARTMENT policies and procedures as they relate to the enrollment process and their comments will be solicited. The CONTRACTOR agrees to be bound by such changes in DEPARTMENT policies and procedures that are mutually agreed upon by the CONTRACTOR and the DEPARTMENT.

B. MEMBER ORIENTATION

1. INITIAL CONTACT - GENERAL ORIENTATION

The CONTRACTOR will make a good faith effort to ensure that each Enrollee or Enrollee's family or guardian receives the CONTRACTOR's member handbook. The CONTRACTOR representative will make a good faith effort, as evidenced in written or electronic records, to make an initial contact with the Enrollee within 10 working days

after the CONTRACTOR has been notified through the Eligibility Transmission of the Enrollee's MCO enrollment. The initial contact will be in person or by telephone (or in writing, but only if reasonable attempts have been made to make the contact in person by telephone) and will inform the Enrollee of the MCO rules and policies. The CONTRACTOR must ensure that Enrollees are provided interpreters, Telecommunication Device for the Deaf (TDD), and other auxiliary aids to ensure that Enrollees understand their rights and responsibilities. During the initial contact the CONTRACTOR Representative will provide, at a minimum, the following information to the Enrollee or potential Enrollee:

a. specific written and oral instructions on the use of the CONTRACTOR's Covered Services and procedures;

b. availability and accessibility of all Covered Services, including the availability of family planning services and that the Enrollee may obtain family planning services from Medicaid providers other than providers affiliated with the CONTRACTOR;

c. the client's rights and responsibilities as an Enrollee of the Health Plan, including the right to file a grievance and how to file a grievance;

d. the right to terminate enrollment with the MCO; and

e. encouragement to make a medical appointment with a provider.

2. IDENTIFICATION OF ENROLLEES WITH SPECIAL HEALTH CARE NEEDS

During the initial contact with each Enrollee, the CONTRACTOR representative will use a process that will identify children and adults with special health care needs. The CONTRACTOR representative will clearly describe to each Enrollee during the initial contact the process for requesting specialist care. When an Enrollee is identified as having special health care needs, the CONTRACTOR Representative will forward this information to a CONTRACTOR individual with knowledge of coordination of care and services necessary for such Enrollees. The CONTRACTOR individual with knowledge of coordination of care for Enrollees with special health care needs will make a good faith effort to contact Enrollees within ten working days after identification to begin coordination of health care needs, if necessary. The CONTRACTOR will not discriminate on the basis of health status or the need for health care services.

The DEPARTMENT's Health Program Representatives are responsible to forward information, i.e., pink sheets identifying Enrollees with special health care needs and limited language proficiency needs to the CONTRACTOR in a timely way coinciding with the daily Eligibility Transmission as much as possible.

3. INABILITY TO CONTACT ENROLLEE FOR ORIENTATION

If the CONTRACTOR's representative cannot contact the Enrollee within 10 working days or at all, the CONTRACTOR representative will document its efforts to contact the Enrollee.

4. ENROLLEES RECEIVING OUT-OF-PLAN CARE PRIOR TO ORIENTATION

If the Enrollee receives Covered Services by an out-of-plan provider after the first day of the month in which the client's enrollment became effective, and if a CONTRACTOR orientation either in-person or by telephone (or in writing, but only if reasonable attempts have been made to make the contact in person or by telephone) has not taken place prior to receiving such services, the CONTRACTOR is responsible for payment of the services rendered provided the DEPARTMENT informs the CONTRACTOR by the 20th of any month prior to the month that MCO enrollment begins.

C. MARKETING AND MEMBER EDUCATION

1. APPROVAL OF MARKETING MATERIALS

The CONTRACTOR's marketing plans, procedures and materials will be accurate, and may not mislead, confuse, or defraud either Enrollees or the DEPARTMENT. All Medicaid marketing plans, procedures and materials will be reviewed and approved by the DEPARTMENT in consultation with the Medical Care Advisory Committee for Marketing Review before implemented or released by the CONTRACTOR. The DEPARTMENT will notify the CONTRACTOR of its approval or disapproval, in writing, of such materials within ten working days after receiving them unless the DEPARTMENT and the CONTRACTOR agree to another time frame. If the DEPARTMENT does not respond within the agreed upon time frame, the CONTRACTOR shall deem such materials approved. Marketing materials will not be approved if the DEPARTMENT determines that the material is materially inaccurate or misleading or otherwise makes material misrepresentations. Health education materials and newsletters not specifically related to Enrollees do not need to be approved by the DEPARTMENT.

a. NO DOOR-TO-DOOR, TELEPHONIC, OR "COLD CALL" MARKETING

The CONTRACTOR cannot, either directly or indirectly, conduct door-to-door, telephonic or "cold call" marketing of enrollment. These three marketing practices are prohibited whether conducted by the Health Plan itself ("directly") or by an agent or independent contractor ("indirectly"). Cold call marketing is any unsolicited personal contact with a potential Enrollee by an employee or agent of a managed care entity for the purpose of influencing the individual to enroll with the Health Plan. The CONTRACTOR may not entice a potential Enrollee to join the Health Plan by offering the sale of any other type of

insurance as a bonus for enrollment. All other non-requested marketing approaches to Medicaid clients by the CONTRACTOR are also prohibited unless specifically approved in advance by the DEPARTMENT.

b. DISTRIBUTION OF MARKETING MATERIALS

Marketing materials must be distributed to the entire Service Area.

2. ENROLLEE MATERIALS MUST BE COMPREHENSIBLE

The CONTRACTOR will attempt to write all Enrollee and potential Enrollee information, instructional and educational materials, including member handbooks, at no greater than a sixth grade reading level. If the MCO has more than 5% of its Enrollees who speak a language other than English as a first language, the CONTRACTOR must make available written material (e.g. member handbooks, educational newsletters) in that language. Marketing materials must include a statement that the CONTRACTOR does not discriminate against any Enrollee on the basis of race, color, national origin, disability, or age in admission, treatment, or participation in its programs, services and activities. In addition, the materials must include the phone number of the nondiscrimination coordinator for Enrollees to call if they have questions about the nondiscrimination policy or desire to file a complaint or grievance alleging violations of the nondiscrimination policy.

3. MEMBER HANDBOOK

The CONTRACTOR will produce a member handbook that must be submitted to the DEPARTMENT for review and approval before distribution. The DEPARTMENT will notify the CONTRACTOR in writing of its approval or disapproval within ten working days after receiving the member handbook unless the DEPARTMENT and CONTRACTOR agree to another time frame. If the DEPARTMENT does not respond within the agreed upon time frame, the CONTRACTOR may deem such materials are approved. If there are changes to the content of the material in the handbook, the CONTRACTOR must update the member handbook and submit a draft to the DEPARTMENT for review and approval before distribution to its Enrollees. At a minimum, the member handbook must explain in clear terms the following information:

a. The scope of benefits provided by the MCO;

b. Instructions on where and how to obtain Covered Services, including referral requirements;

c. Instructions on what to do in an emergency or urgent medical situation, including emergency numbers;

d. Enrollee options on obtaining family planning services;

e. Instructions on how to choose a PCP and how to change PCPs;

f. Description on Enrollee cost-sharing requirements (if applicable);

g. Toll-free telephone number;

h. Description of Member Services function;

i. How to register a complaint or grievance;

j. Information on Advance Directives;

k. Services covered by Medicaid, but not covered by the CONTRACTOR;

l. Clients' rights and responsibilities;

m. A statement that the CONTRACTOR does not discriminate against any Enrollee on the basis of race, color, national origin, disability, or age in admission, treatment, or participation in its programs, services and activities; and

n. The phone number of the nondiscrimination coordinator for Enrollees to call if they have questions about the nondiscrimination policy or desire to file a complaint or grievance alleging violations of the nondiscrimination policy.

4. NOTIFICATION TO ENROLLEES OF POLICIES AND PROCEDURES

a. CHANGES TO POLICIES AND PROCEDURES

The CONTRACTOR must periodically notify Enrollees, in writing, of changes to its plan such as changes to its policies or procedures either through a newsletter or other means.

b. ANNUAL EDUCATION ON EMERGENCY CARE AND GRIEVANCE PROCEDURES

The CONTRACTOR must annually reinforce, in writing, to Enrollees how to access emergency and urgent services and how to register a complaint or grievance.

5. MONTHLY NOTIFICATION TO DEPARTMENT OF CHANGES IN PROVIDER NETWORK

The CONTRACTOR must notify the DEPARTMENT at least monthly of changes in its provider network so that the DEPARTMENT can ensure its listing of providers is accurate.

D. DISENROLLMENT BY ENROLLEE

1. ENROLLEE'S RIGHT TO DISENROLL

Enrollees will have the right to disenroll from this MCO at any time with or without cause. The disenrollment will be effective once the DEPARTMENT has been notified by the Enrollee and the DEPARTMENT issues a new Medicaid card and the disenrollment is indicated on the Eligibility Transmission.

2. ENROLLEES IN AN INPATIENT HOSPITAL SETTING

The DEPARTMENT agrees that if a new Enrollee is a patient in an inpatient hospital setting on the date the new Enrollee's name appears on the CONTRACTOR Eligibility Transmission, the obligation of the CONTRACTOR to provide Covered Services to such person will commence following discharge. If an Enrollee is a patient in an inpatient hospital setting on the date that his or her name appears as a deleted Enrollee on the CONTRACTOR Eligibility Transmission or he or she is otherwise disenrolled under this Contract, the CONTRACTOR will remain financially responsible for such care until discharge.

3. ANNUAL STUDY OF ENROLLEES WHO DISENROLLED

Annually, the DEPARTMENT and CONTRACTOR will work cooperatively to conduct an analysis of Enrollees who have voluntarily disenrolled from this MCO. The results of the analysis will include explanations of patterns of disenrollments and strategies or a corrective action plan to address unusual rates or patterns of disenrollment. The DEPARTMENT will inform the CONTRACTOR of such disenrollments.

E. DISENROLLMENT BY CONTRACTOR

1. CANNOT DISENROLL FOR ADVERSE CHANGE IN ENROLLEE'S HEALTH

The CONTRACTOR may not terminate enrollment because of an adverse change in the Enrollee's health.

2. VALID REASONS FOR DISENROLLMENT

The CONTRACTOR may initiate disenrollment of any Enrollee's participation in the MCO upon one or more of the following grounds:

a. For reasons specifically identified in the CONTRACTOR's member handbook.

b. When the Enrollee ceases to be eligible for medical assistance under the State Plan, in accordance with Title 42 USCA, 1396, et. seq., and as finally determined by the DEPARTMENT.

c. Upon termination or expiration of the Contract.

d. Death of the Enrollee.

e. Confinement of the Enrollee in an institution when confinement is not a Covered Service under this Contract.

f. Violation of enrollment requirements developed by the CONTRACTOR and approved by the DEPARTMENT but only after the CONTRACTOR and/or the Enrollee has exhausted the CONTRACTOR's applicable internal grievance procedure.

3. APPROVAL BY DEPARTMENT REQUIRED

To initiate disenrollment of an Enrollee's participation with this MCO, the CONTRACTOR will provide the DEPARTMENT with documentation justifying the proposed disenrollment. The DEPARTMENT will approve or deny the disenrollment request in writing within thirty (30) days of receipt of the request. Failure by the DEPARTMENT to deny a disenrollment request within such thirty (30) day period will constitute approval of such disenrollment requests.

4. ENROLLEE'S RIGHT TO FILE A GRIEVANCE

If the DEPARTMENT approves the CONTRACTOR's disenrollment request, the CONTRACTOR will give the Enrollee thirty (30) days written notice of the proposed disenrollment, and will notify the Enrollee of his or her opportunity to invoke the internal grievance procedure and appeals process for a fair hearing. The CONTRACTOR will give a copy of the written notice to the DEPARTMENT at the time the notice is sent to the Enrollee.

5. REFUSAL OF RE-ENROLLMENT

If a person is disenrolled because of violation of responsibilities included in the CONTRACTOR'S member handbook, the CONTRACTOR may refuse re-enrollment of that Enrollee.

F. ENROLLEE TRANSITION BETWEEN MCOs/HEALTH PLANS

1. MUST ACCEPT PRE-ENROLLMENT PRIOR AUTHORIZATIONS

For Covered Services other than inpatient, home health services, and medical equipment, if authorization has been given for a Covered Service and an enrollee transitions between MCOs prior to the delivery of such Covered Service, the receiving MCO shall be bound by the relinquishing MCO's prior authorization until the receiving MCO has evaluated the Enrollee and a new plan of care is established. (See Article IV, Benefits, Section F,

Clarification of Payment Responsibilities, Subsection 5, for inpatient, home health services, and medical equipment explanations.)

2. MUST PROVIDE MEDICAL RECORDS TO ENROLLEE'S NEW MCO

When enrollees are transitioned between MCOs the relinquishing MCO's provider will submit, upon request of the new MCO's provider, any critical medical information about the transitioning enrollee prior to the transition including, but not limited to, whether the member is hospitalized, pregnant, involved in the process of organ transplantation, scheduled for surgery or post-surgical follow-up on a date subsequent to transition, scheduled for prior-authorized procedures or therapies on a date subsequent to transition, receiving dialysis or is chronically ill (e.g. diabetic, hemophilic, HIV positive).

ARTICLE IV - BENEFITS

A. IN GENERAL

The CONTRACTOR will provide to Enrollees under this Contract, directly or through arrangements with subcontractors, all Medically Necessary Covered Services described in Attachment C as promptly and continuously as is consistent with generally accepted standards of medical practice. The subcontractors will follow generally accepted standards of medical care in diagnosing Enrollees who request services from the CONTRACTOR.

B. PROVIDER SERVICES FUNCTION

The CONTRACTOR must operate a Provider Services function during regular business hours. At a minimum, Provider Services staff must be responsible for the following:

1. Training, including ongoing training, of the CONTRACTOR's providers on Medicaid rules and regulations that will enable providers to appropriately render services to Enrollees;

2. Assisting providers to verify whether an individual is enrolled with the MCO;

3. Assisting providers with prior authorization and referral protocols;

4. Assisting providers with claims payment procedures;

5. Fielding and responding to provider questions and complaints and grievances.

C. SCOPE OF SERVICES

1. UNDERWRITING RISK

In consideration of the premiums paid by the DEPARTMENT, the CONTRACTOR will, for all Enrollees, assume underwriting risk for Covered Services in Attachment C.

2. RESPONSIBLE FOR ALL BENEFITS IN ATTACHMENT C (COVERED SERVICES)

Except as otherwise provided for cases of Emergency Services, the CONTRACTOR has the exclusive right and responsibility to arrange for all benefits listed in Attachment C. The CONTRACTOR is responsible for payment of Emergency Services 24 hours a day and 7 days a week whether the service was provided by a network or out-of-network provider and whether the service was provided in or out of the CONTRACTOR's Service Area.

3. CHANGES TO BENEFITS

Amendments, revisions, or additions to the State Plan or to State or Federal regulations, guidelines, or policies and court or administrative orders will, insofar as they affect the scope or nature of benefits available to Enrollees, be amendments to the Covered Services under Attachment C. The DEPARTMENT will notify the CONTRACTOR, in writing, of any such changes and their effective date. Rate adjustments, when appropriate, will be negotiated between the DEPARTMENT and the CONTRACTOR.

4. MEDICAL NECESSITY DENIALS

When the CONTRACTOR determines that a service will not be covered due to the lack of medical necessity, the CONTRACTOR must send all documentation supporting their decision to the DEPARTMENT for its review before the CONTRACTOR's determination is deemed final, when the following conditions are met:

a. there are no established national standards for determining medical necessity; and

b. the DEPARTMENT does not have medical necessity criteria for the service.

The DEPARTMENT will review the documentation and determine what the DEPARTMENT's decision would be regarding coverage for the service. The DEPARTMENT and the CONTRACTOR will work collaboratively in making a final decision on whether the service is to be covered by the CONTRACTOR.

D. SUBCONTRACTS

1. NO DISCRIMINATION BASED ON LICENSE OR CERTIFICATION

The CONTRACTOR shall not discriminate against providers with respect to participation, reimbursement, or indemnification as to any provider who is 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.

2. ANY COVERED SERVICE MAY BE SUBCONTRACTED.

Any Covered Service may be subcontracted. All subcontracts will be in writing and will include the general requirements of this Contract that are appropriate to the service or activity including confidentiality requirements and will assure that all duties of the CONTRACTOR under this Contract are performed. No subcontract terminates the legal responsibility of the CONTRACTOR to the DEPARTMENT to assure that all activities under this Contract are carried out. The CONTRACTOR will make all subcontracts available upon request.

3. NO PROVISIONS TO REDUCE OR LIMIT MEDICALLY NECESSARY SERVICES

The CONTRACTOR will ensure that subcontractors abide by the requirements of Section 1128(b) of the Social Security Act prohibiting the CONTRACTOR and other such providers from making payments directly or indirectly to a physician or other provider as an inducement to reduce or limit Medically Necessary services provided to Enrollees.

4. REQUIREMENT OF 60 DAYS WRITTEN NOTICE PRIOR TO TERMINATION OF CONTRACT

All subcontracts and agreements will include a provision stating that if either party (the subcontractor or CONTRACTOR) wishes to terminate the subcontract or agreement, whichever party initiates the termination will give the other party written notice of termination at least 60 calendar days prior to the effective termination date. The CONTRACTOR will notify the DEPARTMENT of the termination on the same day that the CONTRACTOR either initiates termination or receives the notice of termination from the subcontractor.

5. COMPLIANCE WITH CONTRACTOR's QUALITY ASSURANCE PLAN

All of the CONTRACTOR's providers must be aware of the CONTRACTOR's Quality Assurance Plan and activities. All subcontracts with the CONTRACTOR must include a requirement securing cooperation with the CONTRACTOR's Quality Assurance Plan and activities and must allow the CONTRACTOR access to the subcontractor's medical records of its Enrollees.

6. UNIQUE IDENTIFIER REQUIRED

All physicians who provide services under this Contract must have a unique identifier in accordance with the system established under section 1173(b) of the Social Security Act and in accordance with the Health Insurance Portability and Accountability Act.

7. PAYMENT OF PROVIDER CLAIMS

The CONTRACTOR must pay its providers on a timely basis consistent with the claims payment procedures described in section 1902(a)(37)(A) of the Social Security Act and the implementing Federal regulation at 42 CFR 447.45, unless the provider and CONTRACTOR agree to an alternate payment schedule. The Contractor must ensure that 90 percent of claims for payment (for which no further written information or substantiation is required in order to make payment) made for Covered Services and furnished by its providers are paid within 30 days of receipt of such claims and that 99 percent of such claims are paid within 90 days of the date of receipt of such claims.

E. CLARIFICATION OF COVERED SERVICES

1. EMERGENCY SERVICES

a. IN GENERAL

The CONTRACTOR must provide coverage for Emergency Services without regard to prior authorizations or the emergency care provider's contractual relationship with the CONTRACTOR. The CONTRACTOR must inform their Enrollees that access to Emergency Services is not restricted and that if an Enrollee experiences a medical emergency, he or she may obtain services from a non-plan physician or other qualified provider, without penalty. However, the CONTRACTOR may require the Enrollee to notify the CONTRACTOR within a specified time after the Enrollee's condition is stabilized, and may require the Enrollee to obtain prior authorization for any follow-up care delivered pursuant to the emergency. The CONTRACTOR must comply with Medicare guidelines for post-stabilization of care.

The CONTRACTOR must pay for services where the presenting symptoms are of sufficient severity that a person with average knowledge of health and medicine would reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of a woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

The CONTRACTOR may 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, turned out to be non-emergency in nature.

b. DETERMINING LIABILITY FOR EMERGENCY SERVICES

1) Presence of a clinical emergency

If the screening examination leads to a clinical determination by the examining physician that an actual emergency medical condition exists, the CONTRACTOR must pay for both the services involved in the screening examination and the services required to stabilize the Enrollee.

2) Emergency services continue until the Enrollee can be safely discharged or transferred

The CONTRACTOR must pay for all Emergency Services that 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 Enrollee's condition is likely to result from, or occur during, discharge of the Enrollee or transfer of the Enrollee to another facility. If there is a disagreement between a hospital and the CONTRACTOR concerning whether the Enrollee is stable enough for discharge or transfer, or whether the medical benefits of an unstabilized transfer outweigh the risks, the judgement of the attending physician(s) actually caring for the Enrollee at the treating facility prevails and is binding on the CONTRACTOR. The CONTRACTOR may establish arrangements with hospitals whereby the CONTRACTOR may send one of its own physicians with appropriate ER privileges to assume the attending physician's responsibilities to stabilize, treat, and transfer the Enrollee.

3) Absence of a clinical emergency

If the screening examination leads to a clinical determination by the examining physician that an actual emergency medical condition did not exist, then the determining factor for payment liability should be whether the Enrollee had acute symptoms of sufficient severity at the time of presentation. In these cases, the CONTRACTOR must review the presenting symptoms of the Enrollee and must pay for all services involved in the screening examination where the presenting symptoms (including severe pain) were of sufficient severity to have warranted emergency attention under the prudent layperson standard.

4) Referrals

When an Enrollee's Primary Care Physician or other plan representative instructs the Enrollee to seek emergency care in or out of network, the CONTRACTOR is responsible for payment of the medical screening examination and for other Medically Necessary Emergency Services, without regard to whether the Enrollee meets the prudent layperson standard.

2. CARE PROVIDED IN SKILLED NURSING FACILITIES

a. IN GENERAL: STAYS LASTING 30 DAYS OR LESS

The CONTRACTOR may provide long term care for Enrollees in skilled nursing facilities and then reimburse such facilities when the plan of care includes a prognosis of recovery and discharge within 30 days. It is the responsibility of a CONTRACTOR physician to make the determination if the patient will require the services of a nursing facility for fewer or greater than 30 days.

b. PROCESS FOR STAYS LONGER THAN 30 DAYS

When the prognosis of an Enrollee indicates that long term care greater than 30 days will be required, the following process will occur:

1) The CONTRACTOR will notify the Enrollee, hospital discharge planner, and nursing facility that the CONTRACTOR will not be responsible for the services provided for the Enrollee during the stay at the skilled nursing facility.

2) The CONTRACTOR will notify the DHCF, Bureau of Managed Health Care, of this determination to suspend premium payment for that Enrollee.

3) If the CONTRACTOR incurs expenses, the Bureau of Managed Health Care will determine if the CONTRACTOR will retain the premium for the month during which the Enrollee is admitted to the skilled nursing facility. If the CONTRACTOR does not incur expenses during the month in which the Enrollee is admitted to a skilled nursing facility, the Bureau of Managed Health Care will retract from the CONTRACTOR the premium for that Enrollee.

4) Retraction of the premium payment will be subject to "3" above, but the Eligibility Transmission will indicate the non-payment on the first day of the month following the prognosis determination of greater than 30 days.

5) Premium payment to the CONTRACTOR will recommence beginning the first full month that the Enrollee is no longer residing in the nursing facility.

c. PROCESS FOR STAYS LESS THAN 30 DAYS

When the prognosis of skilled nursing facility services is anticipated to be less than 30 days, but during the 30-day period the CONTRACTOR determines that

the Enrollee will require skilled nursing facility services for greater than 30 days, the following process will be in effect:

1) The CONTRACTOR will notify the nursing facility that a determination has been made that the Enrollee will require services for more than 30 days.

2) The CONTRACTOR will notify the DHCF, Bureau of Managed Health Care, of the determination that the Enrollee will require services in a nursing facility for more than 30 days.

3) If the CONTRACTOR incurs expenses for the Enrollee, the Bureau of Managed Health Care will determine if the CONTRACTOR will retain the premium for the month during which the change in status was determined. If the CONTRACTOR does not incur expenses during the month in which the change in status is determined, the Bureau of Managed Health Care will retract from the CONTRACTOR the premium for that Enrollee.

4) Retraction of the premium payment will be subject to "3" above, but the Recipient Subsystem will indicate the non-payment on the first day of the month following the prognosis determination of more than 30 days.

5) The CONTRACTOR will be responsible for payment for three working days after the CONTRACTOR has notified the nursing facility that skilled nursing care will be required for more than 30 days.

6) Premium payment to the CONTRACTOR will recommence beginning the first full month that the recipient is no longer residing in the nursing facility.

3. ENROLLEES WITH SPECIAL HEALTH CARE NEEDS

a. IN GENERAL

The CONTRACTOR will ensure there is access to all Medically Necessary Covered Services to meet the health needs of Enrollees with special health care needs. Individuals with special health care needs are those who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount beyond that required by adults and children generally.

b. IDENTIFICATION

The CONTRACTOR will identify Enrollees with special health care needs using

a process at the initial contact made by the CONTRACTOR Representative to educate the client and will offer the client care coordination or case management services. Care coordination services are services to assist the client in obtaining Medically Necessary Covered Services from the CONTRACTOR or another entity if the medical service is not covered under the Contract.

c. CHOOSING A PRIMARY CARE PROVIDER

The CONTRACTOR will have a mechanism to inform care givers and, when appropriate, Enrollees with special health care needs about primary care providers who have training in caring for such Enrollees so that an informed selection of a provider can be made. The CONTRACTOR will have primary care providers with skills and experience to meet the needs of Enrollees with special health care needs. The CONTRACTOR will allow an appropriate specialist to be the primary care provider but only if the specialist has the skills to monitor the Enrollee's preventive and primary care services.

d. REFERRALS AND ACCESS TO SPECIALTY PROVIDERS

The CONTRACTOR will ensure there is access to appropriate specialty providers to provide Medically Necessary Covered Services for adults and children with special health care needs. If the CONTRACTOR does not employ or contract with a specialty provider to treat a special health care condition at the time the Enrollee needs such Covered Services, the CONTRACTOR will have a process to allow the Enrollee to receive Covered Services from a qualified specialist who may not be affiliated with the CONTRACTOR. The CONTRACTOR will reimburse the specialist for such care at no less than Medicaid's rate for the service when the service is rendered. The process for requesting specialist's care will be clearly described by the CONTRACTOR and explained to each Enrollee during the initial contact with the Enrollee.

If the CONTRACTOR restricts the number of referrals to specialists, the CONTRACTOR will not penalize those providers who make such referrals for Enrollees with special health care needs.

e. SURVEY OF ENROLLEES WITH SPECIAL HEALTH CARE NEEDS

At least every two years, the CONTRACTOR in conjunction with the DEPARTMENT will survey a sample of Enrollees with special health care needs using a national consumer assessment questionnaire. to evaluate their perceptions of services they have received. The survey process, including the survey instrument, will be standardized and developed collaboratively between the DEPARTMENT and all contracting MCOs. The DEPARTMENT will analyze the results of the surveys. The results and analysis of the surveys will be reviewed by the CONTRACTOR's quality assurance committee for action.

f. COLLABORATION WITH OTHER PROGRAMS

If the individual with special health care needs is enrolled in the Prepaid Mental Health Plan or is enrolled in any of the Medicaid home and community-based waiver programs and is receiving case management services through that program, or is covered by one of the other Medicaid targeted case management programs, the CONTRACTOR care coordinator will collaborate with the appropriate program person, i.e., the targeted case manager, etc., for that program once the program person has contacted the CONTRACTOR care coordinator. When necessary, the CONTRACTOR care coordinator will make an effort to contact the program person of those Enrollees who have medical needs that require such coordination.

The CONTRACTOR must coordinate health care needs for children with special health care needs with the services of other agencies (e.g., mental and substance abuse, public health departments, transportation, home and community based care, developmental disabilities, Title V, local schools, IDA programs, and child welfare), and with families, caregivers, and advocates.

g. REQUIRED ELEMENTS OF A CASE MANAGEMENT SYSTEM

A case management system includes but is not limited to:

1) procedures and the capacity to implement the provision of individual needs assessment including the screening for special needs (e.g. mental health, high risk health problems, functional problems, language or comprehension barriers); the development of an individual treatment plan as necessary based on the needs assessment; the establishment of treatment objectives, treatment follow-up, the monitoring of outcomes, and a process to ensure that treatment plans are revised as necessary. These procedures will be designed to accommodate the specific cultural and linguistic needs of the Enrollee;

2) procedures designed to address those Enrollees, including children with special health care needs, who may require services from multiple providers, facilities and agencies and require complex coordination of benefits and services, including social services and other community resources;

3) a strategy to ensure that all Enrollees and/or authorized Family Members or guardians are involved in treatment planning and consent to the medical treatment;

4) procedures and criteria for making referrals and coordinating care by specialists and sub-specialists that will promote continuity as well as

cost-effectiveness of care; and

5) procedures to provide continuity of care for new Enrollees to prevent disruption in the provision of Covered Services that include, but are not limited to, appropriate case management staff able to evaluate and handle individual case transition and care planning, internal mechanisms to evaluate plan networks and special case needs.

h. HOSPICE

If an Enrollee is receiving hospice services at the time of enrollment in the MCO or if the Enrollee is already enrolled in the MCO and has less than six months to live, the Enrollee will be offered hospice services or the continuation of hospice services if he or she is already receiving such services prior to enrollment in the MCO.

4. INPATIENT HOSPITAL SERVICES

If a CONTRACTOR's provider admits an Enrollee for inpatient hospital care, the CONTRACTOR has the responsibility for all services needed by the Enrollee during the hospital stay that are ordered by the CONTRACTOR's provider. Needed services include but are not limited to diagnostic tests, pharmacy, and physician services, including services provided by psychiatrists. If diagnostic tests conducted during the inpatient stay reveal that the Enrollee's condition is outside the scope of the CONTRACTOR's responsibility, the CONTRACTOR remains responsible for the Enrollee until the Enrollee is discharged or until responsibility is transferred to another appropriate entity and the appropriate entity agrees to take financial responsibility, including negotiating a payment for services. If the Enrollee is discharged and needs further services, the admitting CONTRACTOR will coordinate with the other appropriate entity to ensure continued care is provided. The CONTRACTOR and appropriate entity will work cooperatively in the best interest of the Enrollee. The appropriate entity includes, but is not limited to, a Prepaid Mental Health Plan or another MCO.

5. MATERNITY STAYS

a. THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT (NMHPA)

The CONTRACTOR must meet the requirements of the Newborns' and Mothers' Health Protection Act (NMHPA). The CONTRACTOR must record early discharge information for monitoring, quality, and improvement purposes. The CONTRACTOR will ensure that coverage is provided with respect to a mother who is an Enrollee and her newborn child for a minimum of 48 hours of inpatient care following a normal vaginal delivery, and a minimum of 96 hours of inpatient care following a caesarean section, without requiring the attending provider to obtain authorization from the CONTRACTOR in order to keep a

mother and her newborn child in the inpatient setting for such period of time.

b. EARLY DISCHARGES

Notwithstanding the prior sentence, the CONTRACTOR will not be required to provide coverage for post-delivery inpatient care for a mother who is an Enrollee and her newborn child during such period of time if (1) a decision to discharge the mother and her newborn child prior to the expiration of such period is made by the attending provider in consultation with the mother; and (2) the CONTRACTOR provides coverage for timely post-delivery follow-up care.

c. POST-DELIVERY CARE

Post-delivery care will be provided to a mother and her newborn child by a registered nurse, physician, nurse practitioner, nurse midwife or physician assistant experienced in maternal and child health in (1) the home, a provider's office, a hospital, a federally qualified health center, a federally qualified rural health clinic, or a State health department maternity clinic; or (2) another setting determined appropriate under regulations promulgated by the Secretary of Health and Human Services, (including a birthing center or an intermediate care facility); except that such coverage will ensure that the mother has the option to be provided with such care in the home.

d. TIMELY POST-DELIVERY CARE

"Timely post-delivery care" means health care that is provided (1) following the discharge of a mother and her newborn child from the inpatient setting; and (2) in a manner that meets the health needs of the mother and her newborn child, that provides for the appropriate monitoring of the conditions of the mother and child, and that occurs within the 24 to 72 hour period immediately following discharge.

6. CHILDREN IN CUSTODY OF THE DEPARTMENT OF HUMAN SERVICES

a. IN GENERAL

The CONTRACTOR will work with the Division of Child and Family Services (DCFS) or the Division of Youth Corrections (DYC) in the Department of Human Services (DHS) to ensure systems are in place to meet the health needs of children in custody of the Department of Human Services. The CONTRACTOR will ensure these children receive timely access to appointments through coordination with DCFS or DYC. The CONTRACTOR must have available providers who have experience and training in abuse and neglect issues.

The CONTRACTOR or its providers will make every reasonable effort to ensure

that a child who is in custody of the Department of Human Services may continue to use the provider with whom the child has an established professional relationship when the provider is part of the CONTRACTOR's network. The CONTRACTOR will facilitate timely appointments with the provider of record to ensure continuity of care for the child.

While it is the CONTRACTOR's responsibility to ensure Enrollees who are children in the custody of DHS have access to needed services, DHS personnel are primarily responsible to assist children in custody in arranging for and getting to medical appointments and evaluations with the CONTRACTOR's network of providers. DHS staff are primarily responsible for contacting the CONTRACTOR to coordinate care for children in custody and informing the CONTRACTOR of the special health care needs of these Enrollees. The Fostering Healthy Children staff may assist the DHS staff in performing these functions by communicating with the CONTRACTOR.

b. SCHEDULE OF VISITS

1) Where physical and/or sexual abuse is suspected

In cases where the child protection worker suspects physical and/or sexual abuse, the CONTRACTOR will ensure that the child has access to an appropriate examination within 24 hours of notification that the child was removed from the home. If the CONTRACTOR cannot provide an appropriate examination, the CONTRACTOR will ensure the child has access to a provider who can provide an appropriate examination within the 24 hour period.

2) All other cases

In all other cases, the CONTRACTOR will ensure that the child has access to an initial health screening within five calendar days of notification that the child was removed from the home. The CONTRACTOR will ensure this exam identifies any health problems that might determine the selection of a suitable placement, or require immediate attention.

3) CHEC exams

In all cases, the CONTRACTOR will ensure that the child has access to a Child Health Evaluation and Care (CHEC) screening within 30 calendar days of notification that the child was removed from the home. Whenever possible, the CHEC screening should be completed within the five-day time frame. Additionally, the CONTRACTOR will ensure the child has access to a CHEC screening according to the CHEC periodicity

schedule until age six, then annually thereafter.

7. ORGAN TRANSPLANTATIONS

a. IN GENERAL

All organ transplantation services are the responsibility of the CONTRACTOR for all Enrollees in accordance with the criteria set forth in Rule R414-10A of the Utah Administrative Code, unless amended under the provisions of Attachment B, Article IV (Benefits), Section C, Subsection 3 of this Contract. The DEPARTMENT's criteria will be provided to the CONTRACTOR.

b. SPECIFIC ORGAN TRANSPLANTATIONS COVERED

The following transplantations are covered under Rule R414-10A: Kidney, liver, cornea, bone marrow, heart, intestine, lung, pancreas, small bowel, combination heart/lung, combination intestine/liver, combination kidney/pancreas, combination liver/kidney, multi visceral, and combination liver/small bowel.

c. PSYCHOSOCIAL EVALUATION REQUIRED

Enrollees who have applied for organ transplantations, except cornea or kidney, must undergo a comprehensive psycho-social evaluation by a board-certified or board-eligible psychiatrist. The evaluation must include a comprehensive history regarding substance abuse and compliance with medical treatment. In addition, the parent(s) or guardian(s) of Enrollees who are less than 18 years of age must undergo a psycho-social evaluation that includes a comprehensive history regarding substance abuse, and past and present compliance with medical treatment.

If a request is made for a transplantation not listed above, the CONTRACTOR will contact the DEPARTMENT. Such requests will be addressed as set forth in R414-10A-23.

d. OUT-OF-STATE TRANSPLANTATIONS

When the CONTRACTOR arranges the transplantation to be performed out-of- state, the CONTRACTOR is responsible for coverage of food, lodging, transportation and airfare expenses for the Enrollee and attendant. The CONTRACTOR will follow, at a minimum, the DEPARTMENT's criteria for coverage of food, lodging, transportation and airfare expenses.

8. MENTAL HEALTH SERVICES

When an Enrollee presents with a possible mental health condition to his or her

CONTRACTOR primary care physician, it is the responsibility of the primary care provider to determine whether the Enrollee should be referred to a psychologist, pediatric specialist, psychiatrist, neurologist, or other specialist. Mental health conditions may be handled by the CONTRACTOR primary care provider and referred to the Enrollee's Prepaid Mental Health Plan when more specialized services are required for the Enrollee. CONTRACTOR primary care providers may seek consultation from the Prepaid Mental Health Plan when the primary care provider chooses to manage the Enrollee's symptoms.

An independent panel comprised of specialists appropriate to the concern will be established by the DEPARTMENT with representatives from the CONTRACTOR and Prepaid Mental Health Plan to adjudicate disputes regarding which entity (the CONTRACTOR or Prepaid Mental Health Plan) is responsible for payment and/or treatment of a condition. The panel will be convened on a case-by-case basis. The CONTRACTOR and Prepaid Mental Health Plan will adhere to the final decision of the panel.

9. DEVELOPMENTAL AND ORGANIC DISORDERS

a. COVERED SERVICES FOR CHILD ENROLLEES THROUGH AGE 20

1) The CONTRACTOR is responsible for all inpatient and physician outpatient Covered Services for child Enrollees with developmental (ICD-9 codes 299 through 299.8 and 317 through 319.9) or organic diagnoses (ICD-9 codes 290 through 294.9 and 310 through 310.9) including, but not limited to, diagnostic work-ups and other medical care such as medication management services related to the developmental or organic disorder.

2) The CONTRACTOR is responsible for all psychological evaluations and testing including neuropsychological evaluations and testing for child Enrollees with developmental or organic disorders such as brain tumors, brain injuries, and seizure disorders.

b. COVERED SERVICES FOR ADULT ENROLLEES AGE 21 AND OLDER

The CONTRACTOR is responsible for all inpatient and physician outpatient Covered Services for adult Enrollees with developmental (ICD-9 codes 299 through 299.8 and 317 through 319.9) and organic diagnoses (ICD-9 codes 290 through 294.9 and 310 through 310.9) including diagnostic work-ups and other medical care such as medication management services related to the developmental or organic disorder.

c. NON-COVERED SERVICES

1) Psychological evaluations and testing including neuropsychological

evaluations and testing for adult Enrollees is not the responsibility of the CONTRACTOR.

2) Habilitative and behavioral management services are not the responsibility of the CONTRACTOR. If habilitative services are required, the Enrollee should be referred to the Division of Services for People with Disabilities (DSPD), the school system, the Early Intervention Program, or similar support program or agency. The Enrollee should also be referred to DSPD for consideration of other benefits and programs that may be available through DSPD. Habilitative services are defined in Section 1915(c)(5)(a) of the Social Security Act as "services designed to assist individuals in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community based settings."

d. RESPONSIBILITY OF THE PREPAID MENTAL HEALTH PLAN

The Prepaid Mental Health Plan is responsible for needed mental health services to individuals with an organic and a psychiatric diagnosis or with a developmental and a psychiatric diagnosis.

10. OUT-OF-STATE ACCESSORY SERVICES

When the CONTRACTOR arranges a Covered Service to be performed out-of-state, the CONTRACTOR is responsible for coverage of airfare, food and lodging for the Enrollee and one attendant during the stay at the out-of-state facility. Ground transportation costs only from the airport to the hotel or hospital and back to the airport, one time only are also the responsibility of the CONTRACTOR. The CONTRACTOR will follow, at a minimum, the DEPARTMENT's criteria for coverage of food, lodging, transportation, and airfare expenses.

11. NON-CONTRACTOR PRIOR AUTHORIZATIONS

a. PRIOR AUTHORIZATIONS - GENERAL

The CONTRACTOR shall honor prior authorizations for organ transplantations and any other ongoing services initiated by the DEPARTMENT while the Enrollee was covered under Medicaid fee-for-service until the Enrollee is evaluated by the CONTRACTOR and a new plan of care is established.

b. WHEN THE CONTRACTOR HAS NOT AUTHORIZED THE SERVICE

For services that require a prior authorization, the CONTRACTOR will pay the provider of the service at the Medicaid rate, if the following conditions are met:

1) the servicing provider is not a participating provider under contract with the CONTRACTOR; and

2) the DEPARTMENT issued a prior authorization for an Enrollee to the servicing provider approving payment of the service; and

3) the servicing provider has completed the CONTRACTOR's hearing process without resolution of the claim, and has requested a hearing with the State Formal Hearings Unit requesting payment for the services rendered: and

4) in the hearing process it is determined that service rendered was a Medically Necessary service covered under this Contract, and that the CONTRACTOR will be responsible for payment of the claim.

The CONTRACTOR may elect to have payment of the servicing provider's claim made through the DEPARTMENT's MMIS system, with an equal reduction in the payments made to the CONTRACTOR

F. CLARIFICATION OF PAYMENT RESPONSIBILITIES

1. COVERED SERVICES RECEIVED OUTSIDE CONTRACTOR's NETWORK BUT PAID BY CONTRACTOR

The CONTRACTOR will not be required to pay for Covered Services, defined in Attachment C, which the Enrollee receives from sources outside The CONTRACTOR's network, not arranged for and not authorized by the CONTRACTOR except as follows:

a. Emergency Services;

b. Court ordered services that are Covered Services defined in Attachment C and which have been coordinated with the CONTRACTOR; or

c. Cases where the Enrollee demonstrates that such services are Medically Necessary Covered Services and were unavailable from the CONTRACTOR.

2. WHEN COVERED SERVICES ARE NOT THE CONTRACTOR's RESPONSIBILITY

a. The CONTRACTOR is not responsible for payment when family planning services are obtained by an Enrollee from sources other than the CONTRACTOR.

b. The CONTRACTOR will not be required to provide, arrange for, or pay for Covered Services to Enrollees whose illness or injury results directly from a catastrophic occurrence or disaster, including, but not limited to, earthquakes or

acts of war. The effective date of excluding such Covered Services will be the date specified by the Federal Government or the State of Utah that a Federal or State emergency exists or disaster has occurred.

3. THE DEPARTMENT'S RESPONSIBILITY

Except as described in Attachment F (Rates and Rate-Related Terms) of this Contract, the DEPARTMENT will not be required to pay for any Covered Services under Attachment C which the Enrollee received from any sources outside the CONTRACTOR except for family planning services.

4. COVERED SERVICES PROVIDED BY THE DEPARTMENT OF HEALTH, DIVISION OF COMMUNITY AND FAMILY HEALTH SERVICES

For Enrollees who qualify for special services offered by or through the Department of Health, Division of Community and Family Health Services (DCFHS), the CONTRACTOR agrees to reimburse DCFHS at the standard Medicaid rate in effect at the time of service for one outpatient team evaluation and one follow-up visit for each Enrollee upon each instance that the Enrollee both becomes Medicaid eligible and selects the CONTRACTOR as its provider. The CONTRACTOR agrees to waive any prior authorization requirement for one outpatient team evaluation and one follow-up visit. The services provided in the outpatient team evaluation and follow-up visit for which the CONTRACTOR will reimburse DCFHS are limited to the services that the CONTRACTOR is otherwise obligated to provide under this Contract.

If the CONTRACTOR desires a more detailed agreement for additional services to be provided by or through DCFHS for children with special health care needs, the CONTRACTOR may subcontract with DCFHS. The CONTRACTOR agrees that the subcontract with DCFHS will acknowledge and address the specific needs of DCFHS as a government provider.

5. ENROLLEE TRANSITION BETWEEN MCOS, OR BETWEEN FEE-FOR-SERVICE AND CONTRACTOR

a. INPATIENT HOSPITAL

When an Enrollee is in an inpatient hospital setting and selects another MCO or becomes fee-for-service anytime prior to discharge from the hospital, the CONTRACTOR is financially responsible for the entire hospital stay including all services related to the hospital stay, i.e. physician, etc. The MCO in which the individual is enrolled at the time of discharge from the hospital is financially responsible for services provided during the remainder of the month when the individual was discharged. If such individual is fee-for-service at the time of discharge from the hospital, the DEPARTMENT is financially responsible for the remainder of the month when the individual was discharged. If a Medicaid

eligible is in an inpatient hospital setting and selects the MCO anytime prior to discharge from the hospital, the DEPARTMENT is financially responsible for the entire hospital stay including all services related to the hospital stay, i.e. physician, etc. Enrollees who are in an inpatient hospital setting at the time the CONTRACTOR terminates this Contract and who have enrolled with another MCO are the responsibility of the receiving MCO beginning the day after the termination is effective.

b. HOME HEALTH SERVICES

Medicaid clients who are under fee-for-service or are enrolled in an MCO other than this MCO and are receiving home health services from an agency not contracting with the CONTRACTOR will be transitioned to the CONTRACTOR's home health agency. The CONTRACTOR is responsible for payment, not to exceed Medicaid payment, for a period not to exceed seven calendar days, unless the CONTRACTOR and the home health agency agree to another time period in writing, after the CONTRACTOR notifies the non-participating home health agency of the change in status or the non-participating home health agency notifies the CONTRACTOR that services are being provided by its agency. The CONTRACTOR will assess the needs of the Enrollee at the time the CONTRACTOR provides the orientation to the Enrollee.

The CONTRACTOR will include the Enrollee in developing the plan of care to be provided by the CONTRACTOR's home health agency before the transition is complete. The CONTRACTOR will address Enrollee's concerns regarding Covered Services provided by the CONTRACTOR's home health agency before the new plan of care is implemented.

c. MEDICAL EQUIPMENT

When medical equipment is ordered for an Enrollee by the CONTRACTOR and the Enrollee enrolls in a different MCO before receiving the equipment, the CONTRACTOR is responsible for payment for such equipment. Medical equipment includes specialized wheelchairs or attachments, prosthesis, and other equipment designed or modified for an individual client. Any attachments to the equipment, replacements, or new equipment is the responsibility of the MCO in which the client is enrolled at the time such equipment is ordered.

6. SURVEYS

All surveys required under this Contract will be funded by the CONTRACTOR unless funded by another source such as the Utah Department of Health, Office of Health Care Statistics. The surveys must be conducted by an independent vendor mutually agreed upon by the DEPARTMENT and CONTRACTOR. The DEPARTMENT or designee will analyze the results of the surveys. Before publishing articles, data, reports, etc.

related to surveys the DEPARTMENT will provide drafts of such material to the CONTRACTOR for review and feedback. The CONTRACTOR will not be responsible for the costs incurred for such publishing by the DEPARTMENT.

ARTICLE V - ENROLLEE RIGHTS/SERVICES

A. MEMBER SERVICES FUNCTION

The CONTRACTOR must operate a Member Services function during regular business hours. Ongoing training, as necessary, shall be provided by the CONTRACTOR to ensure that the Member Services staff is conversant in the CONTRACTOR's policies and procedures as they relate to Enrollees. At a minimum, Member Services staff must be responsible for the following:

1. Explaining the CONTRACTOR's rules for obtaining services;

2. Assisting Enrollees to select or change primary care providers;

3. Fielding and responding to Enrollee questions and complaints and grievances.

The CONTRACTOR shall conduct ongoing assessment of its orientation staff to determine staff member's understanding of the MCO and its Medicaid managed care policies and provide training, as needed.

B. ENROLLEE LIABILITY

1. The CONTRACTOR will not hold an Enrollee liable for the following:

   a. The debts of the CONTRACTOR if it should become insolvent.

   b. Payment for services provided by the CONTRACTOR if the CONTRACTOR has not received payment from the DEPARTMENT for the services, or if the provider, under contract with the CONTRACTOR, fails to receive payment from the CONTRACTOR.

   c. The payments to providers that furnish Covered Services under a contract or other arrangement with the CONTRACTOR that are in excess of the amount that normally would be paid by the Enrollee if the service had been received directly from the CONTRACTOR.

C. GENERAL INFORMATION TO BE PROVIDED TO ENROLLEES

The CONTRACTOR will make the following information available to Enrollees and potential Enrollees on request:

1. The identity, locations, qualification, and availability of participating providers (at a

minimum, area of specialty, board certification, and any special areas of expertise must be available that would be helpful to individuals deciding whether to enroll with the CONTRACTOR);

2. The rights and responsibilities of Enrollees;

3. The procedures available to Enrollees and providers to challenge or appeal the failure of the CONTRACTOR to cover a services; and

4. All items and services that are available to Enrollees that are covered either directly or through a method of referral or prior authorization.

D. ACCESS

1. IN GENERAL

The CONTRACTOR shall provide the DEPARTMENT and the Department of Health and Human Services, Centers for Medicare and Medicaid, adequate assurances that the CONTRACTOR, with respect to a service area, has the capacity to serve the expected enrollment in such service area, including assurances that the CONTRACTOR offers an appropriate range of services and access to preventive and primary care services for the population expected to enroll in such service area, and maintains a sufficient number, mix and geographic distribution of providers of services.

The CONTRACTOR will provide services which are accessible to Enrollees and appropriate in terms of timeliness, amount, duration, and scope.

2. SPECIFIC PROVISIONS

a. ELIMINATION OF ACCESS PROBLEMS CAUSED BY GEOGRAPHIC, CULTURAL AND LANGUAGE BARRIERS AND PHYSICAL DISABILITIES

The CONTRACTOR will minimize, with a goal to eliminate, Enrollee's access problems due to geographic, cultural and language barriers, and physical disabilities. The CONTRACTOR will provide assistance to Enrollees who have communication impediments or impairments to facilitate proper diagnosis and treatment. The CONTRACTOR must guarantee equal access to services and benefits for all Enrollees by making available interpreters, Telecommunication Devices for the Deaf (TDD), and other auxiliary aids to all Enrollees as needed. The CONTRACTOR will accommodate Enrollees with physical and other disabilities in accordance with the American Disabilities Act of 1990 (ADA), as amended. If the CONTRACTOR's facilities are not accessible to Enrollees with physical disabilities, the CONTRACTOR will provide services in other accessible locations.

b. INTERPRETIVE SERVICES

The CONTRACTOR will provide interpretive services for languages on an as needed basis. These requirements will extend to both in-person and telephone communications to ensure that Enrollees are able to communicate with the CONTRACTOR and CONTRACTOR's providers and receive Covered Services. Professional interpreters will be used when needed where technical, medical, or treatment information is to be discussed, or where use of a Family Member or friend as interpreter is inappropriate. A family member or friend may be used as an interpreter if this method is requested by the patient, and the use of such a person would not compromise the effectiveness of services or violate the patient's confidentiality, and the patient is advised that a free interpreter is available.

c. CULTURAL COMPETENCE REQUIREMENTS

The CONTRACTOR shall incorporate in its policies, administration, and delivery of services the values of honoring Enrollee's beliefs; being sensitive to cultural diversity; and promoting attitudes and interpersonal communication styles with staff and providers which respect Enrollees' cultural backgrounds. The CONTRACTOR must foster cultural competency among its providers. Culturally competent care is care given by a provider who can communicate with the Enrollee and provide care with sensitivity, understanding, and respect for the Enrollee's culture, background and beliefs. The CONTRACTOR shall strive to ensure its providers provide culturally sensitive services to Enrollees. These services shall include but are not limited to providing training to providers regarding how to promote the benefits of health care services as well as training about health care attitudes, beliefs, and practices that affect access to health care services.

d. NO RESTRICTIONS OF PROVIDER's ABILITY TO ADVISE AND COUNSEL

The CONTRACTOR may not restrict a health care provider's ability to advise and counsel Enrollees about Medically Necessary treatment options. All contracting providers acting within his or her scope of practice, must be permitted to freely advise an Enrollee about his or her health status and discuss appropriate medical care or treatment for that condition or disease regardless of whether the care or treatment is a Covered Service.

e. WAITING TIME BENCHMARKS

The CONTRACTOR will adopt benchmarks for waiting times for physician appointments as follows:

Waiting Time for Appointments

1) Primary Care Providers:
   - within 30 days for routine, non-urgent appointments
   - within 60 days for school physicals
   - within 2 days for urgent, symptomatic, but not life-threatening care (care that can be treated in the doctor's office)

2) Specialists:
   - within 30 days for non-urgent
   - within 2 days for urgent, symptomatic, but not life-threatening care (care that can be treated in a doctor's office)

These benchmarks do not apply to appointments for regularly scheduled visits to monitor a chronic medical condition if the schedule calls for visits less frequently than once every month.

f. NO DELAY WHILE COORDINATING COVERAGE WITH A PREPAID MENTAL HEALTH PLAN

When an Enrollee is also enrolled in a Prepaid Mental Health Plan, the CONTRACTOR will not delay an Enrollee's access to needed services in disputes regarding responsibility for payment. Payment issues should be addressed only after needed services are rendered. As described in Attachment B, IV (Benefits), Section E (Clarification of Covered Services), Subsection 8 of this Contract, the independent panel established by the DEPARTMENT will assist in adjudicating such disputes when requested to do so by either party.

E. CHOICE

The CONTRACTOR must allow Enrollees the opportunity to select a participating Primary Care Provider. This excludes clients who are under the Restriction Program. If an Enrollee's Primary Care Provider ceases to participate in the CONTRACTOR's network, the CONTRACTOR must offer the Enrollee the opportunity to select a new Primary Care Provider.

F. COORDINATION

1. IN GENERAL

The CONTRACTOR will ensure access to a coordinated, comprehensive and continuous array of needed services through coordination with other appropriate entities. The CONTRACTOR's providers are not responsible for rendering waiver services.

2. PREPAID MENTAL HEALTH PLAN

a. When an Enrollee is also enrolled in a Prepaid Mental Health Plan, the CONTRACTOR and Prepaid Mental Health Plan will share appropriate information regarding the Enrollee's health care to ensure coordination of physical and mental health care services.

b. Clients enrolled in the MCO and a Prepaid Mental Health Plan who due to a psychiatric condition require lab, radiology and similar outpatient services covered under this Contract, but prescribed by the Prepaid Mental Health Plan physician, will have access to such services in a timely fashion. The CONTRACTOR and Prepaid Mental Health Plan will reduce or eliminate unnecessary barriers that may delay the Enrollee's access to these critical services.

3. DOMESTIC VIOLENCE

The CONTRACTOR will ensure that providers are knowledgeable about methods to detect domestic violence and about resources in the community to which they can refer patients.

4. RESTRICTION PCP

The CONTRACTOR will ensure that Enrollees who are on the Restriction Program are linked to a primary care physician (PCP). If the restricted Enrollee's PCP chooses to no longer serve as the Enrollee's PCP or the provider ceases participation with the CONTRACTOR, the CONTRACTOR must assist the Enrollee in finding a new PCP.

G. BILLING ENROLLEES

1. IN GENERAL

Except as provided herein Attachment B, Article V (Enrollee Rights/Services), Section G (Billing Enrollees), subsection 2, no claim for payment will be made at any time by the CONTRACTOR or its providers to an Enrollee accepted by that provider as an Enrollee for any Covered Service. When a provider accepts an Enrollee as a patient he or she will look solely to the CONTRACTOR and any third party coverage for reimbursement. If the provider fails to receive payment from the CONTRACTOR, the Enrollee cannot be held responsible for these payments.

2. CIRCUMSTANCES WHEN AN ENROLLEE MAY BE BILLED

An Enrollee may in certain circumstances be billed by the provider for non-Covered Services. A non-Covered Service is one that is not covered under this Contract, or includes special features or characteristics that are desired by the Enrollee, such as more expensive eyeglass frames, hearing aids, custom wheelchairs, etc., but do not meet the Medical Necessity criteria for amount, duration, and scope as set forth in the Utah State Plan. The DEPARTMENT will specify to the CONTRACTOR the extent of Covered Services and items under the Contract, as well as services not covered under the Contract but provided by Medicaid on a fee-for-service basis that would effect the CONTRACTOR's Covered Services. An Enrollee may be billed for a service not covered under this Contract only when all of the following conditions are met:

a. the provider has an established policy for billing all patients for services not covered by a third party (non-Covered Services cannot be billed only to Enrollees.);

b. the provider has informed the Enrollee of its policy and the services and items that are not covered under this Contract and included this information in the Enrollee's member handbook;

c. the provider has advised the Enrollee prior to rendering the service that the service is not covered under this Contract and that the Enrollee will be personally responsible for making payment; and

d. the Enrollee agrees to be personally responsible for the payment and an agreement is made in writing between the provider and the Enrollee which details the service and the amount to be paid by the Enrollee.

3. CONTRACTOR MAY NOT HOLD ENROLLEE'S MEDICAID CARD

The CONTRACTOR or its providers will not hold the Enrollee's Medicaid card as guarantee of payment by the Enrollee, nor may any other restrictions be placed upon the Enrollee.

4. CRIMINAL PENALTIES

Criminal penalties shall be imposed on MCO providers as authorized under section 1128B(d)(1)of the Social Security Act if the provider knowingly and willfully charges an Enrollee at a rate other than those allowed under this Contract.

H. SURVEY REQUIREMENTS

Surveys will be conducted of the CONTRACTOR's Enrollees that will include questions about Enrollees' perceptions of access to and the quality of care received through the CONTRACTOR. The survey process, including the survey instrument, will be standardized and developed collaboratively among the DEPARTMENT and all contracting MCOs. The DEPARTMENT will analyze the results of the surveys. The CONTRACTOR's quality assurance committee will review the results of the surveys, identify areas needing improvement, outline action steps to follow up on findings, and inform (at a minimum), subcontractors, and member and provider services staff, when applicable.

1. GENERAL POPULATION SURVEY

At least every two years, the CONTRACTOR in conjunction with the DEPARTMENT will survey a sample of its general population Enrollees; i.e.,

Enrollees who do not meet the definition of those with special health care needs.

2. SPECIAL NEEDS SURVEY

At least every two years, the CONTRACTOR in conjunction with the DEPARTMENT will survey a sample of Enrollees with special health care needs.

ARTICLE VI - GRIEVANCE PROCEDURES

A. IN GENERAL

The CONTRACTOR will maintain a system for reviewing and adjudicating complaints and grievances by Enrollees and providers. The CONTRACTOR's complaint and grievance procedures must permit an Enrollee, or provider on behalf of an Enrollee, to challenge the denials of coverage of medical assistance or denials of payment for Covered Services. The CONTRACTOR will submit such grievance plans and procedures to the DEPARTMENT for approval prior to instituting or changing such procedures. Such procedures will provide for expeditious resolution of complaints and grievances by the CONTRACTOR's personnel who have authority to correct problems. The CONTRACTOR shall ensure that each Enrollee with limited English proficiency shall have the right to receive oral interpreter services without charge to the Enrollee at each stage of the CONTRACTOR's complaint and grievance process, including final determination.

B. NONDISCRIMINATION

The CONTRACTOR shall designate a nondiscrimination coordinator who will 1) ensure the CONTRACTOR complies with Federal Laws and Regulations regarding nondiscrimination, and 2) take complaints and grievances from Enrollees alleging nondiscrimination violations based on race, color, national origin, disability, or age. The nondiscrimination coordinator may also handle complaints regarding the violation of other civil rights (sex and religion) as other Federal laws and Regulations protect against these forms of discrimination. The CONTRACTOR, will develop and implement a written method of administration to assure that the CONTRACTOR's programs, activities, services, and benefits are equally available to all persons without regard to race, color, national origin, disability, or age.

C. MINIMUM REQUIREMENTS OF GRIEVANCE PROCEDURES

At a minimum, the CONTRACTOR's complaint and grievance procedures must include

1. definitions of complaints and grievance;

2. details of how, when, where and with whom an Enrollee or provider may file a

grievance;

3. assurances of the participation of individuals with authority to take corrective action;

4. responsibilities of the various components and staff of the organization;

5. a description of the process for timely review, prompt (45 days) resolution of complaints and grievances;

6. details of an appeal process; and

7. a provision stating that during the pendency of any grievance procedure or an appeal of such grievances, the Enrollee will remain enrolled except as otherwise stated in this Contract.

D. FINAL REVIEW BY DEPARTMENT

When an Enrollee or provider has exhausted the CONTRACTOR's grievance process and a final decision has been made, the CONTRACTOR must provide written notification to the party who initiated the grievance of the grievance's outcome and explain in clear terms a detailed reason for the denial.

The CONTRACTOR must provide notification to Enrollees and providers that the final decision of the CONTRACTOR may be appealed to the DEPARTMENT and will give to the Enrollee or provider the DEPARTMENT's form to request a formal hearing with the DEPARTMENT. The MCO must inform the Enrollee or provider the time frame for filing an appeal with the DEPARTMENT. The formal hearing with the DEPARTMENT is a de novo hearing. If the Enrollee or provider request a formal hearing with the DEPARTMENT, all parties to the formal hearing agree to be bound by the DEPARTMENT's decision until any judicial reviews are completed and are in the Enrollee's or provider's favor. Any decision made by the DEPARTMENT pursuant to the hearing shall be subject to appeal rights as provided by State and Federal laws and rules.

ARTICLE VII - OTHER REQUIREMENTS

A. COMPLIANCE WITH PUBLIC HEALTH SERVICE ACT

The CONTRACTOR will comply with all requirements of Section 1301 to and including 1318 of the Public Health Service Act. The CONTRACTOR will provide verification of such compliance to the DEPARTMENT upon the DEPARTMENT's request. This Contract is a "prospective risk" contract which means that payment is made by means of a capitation rate offered each month as reimbursement in advance for services incurred that month regardless of the level of utilization

actually experienced. Nothing herein will be construed or interpreted to mean that this is a cost reimbursement contract. Cost reimbursement means payment is made by means of a settlement based on cost incurred over a given period.

B. COMPLIANCE WITH OBRA'90 PROVISION AND 42 CFR 434.28

The CONTRACTOR will comply with the OBRA '90 provision which requires an MCO provide patients with information regarding their rights under State law to make decisions about their health care including the right to execute a living will or to grant power of attorney to another individual.

The CONTRACTOR will comply with the requirements of 42 CFR 434.28 relating to maintaining written Advance Directives as outlined under Subpart I of 489.100 through 489.102.

C. FRAUD AND ABUSE REQUIREMENTS

The CONTRACTOR must have a compliance program to identify and refer suspected fraud and abuse activities. The compliance program must outline the CONTRACTOR's internal processes for identifying fraud and abuse. The CONTRACTOR agrees to abide by Federal and/or State fraud and abuse requirements including, but not limited to, the following:

1. Refer in writing to the DEPARTMENT all detected incidents of potential fraud or abuse on the part of providers of services to Enrollees or to other patients.

2. Refer in writing to the DEPARTMENT all detected incidents of patient fraud or abuse involving Covered Services provided which are paid for in whole, or in part, by the DEPARTMENT.

3. Refer in writing to the DEPARTMENT the names and Medicaid ID numbers of those Enrollees that the CONTRACTOR suspects of inappropriate utilization of services, and the nature of the suspected inappropriate utilization.

4. Inform the DEPARTMENT in writing when a provider is removed from the CONTRACTOR's panel for reasons relating to suspected fraud, abuse or quality of care concerns.

5. The CONTRACTOR may not employ or subcontract with any sanctioned provider. The DEPARTMENT shall notify the CONTRACTOR how to access information on providers sanctioned by Medicaid or Medicare. It is the responsibility of the CONTRACTOR to keep apprized of sanctioned providers.

   The CONTRACTOR may not employ or subcontract with any provider who is an ineligible entity as defined under the State Medicaid Manual Section 2086.16. This

section is available upon request. The CONTRACTOR will attest that the entities listed below are not involved with the CONTRACTOR. Entities that must be excluded -

a. Entities that could be excluded under section 1128(b)(8) of the Social Security Act (the Act)--these are entities in which a person who is an officer, director, agent, or managing employee of the entity, or a person who has a direct or indirect ownership or control interest of 5% or more in the entity and has been convicted of the following crimes:

   1) any criminal offense related to the delivery of a Medicare or Medicaid item or service (see section 1128(a)(1) of the Act);

   2) patient abuse (section 1128(a)(2));

   3) fraud (1128(b)(1));

   4) obstruction of an investigation (1128(b)(2)); or

   5) offenses related to controlled substances (1128(b)(3)).

b. Entities that have a direct or indirect substantial contractual relationship with an individual or entity listed in subsection "a" above--a substantial contractual relationship is defined as any contractual relationship which provides for one or more of the following:

   1) the administration, management, or provision of medical services;

   2) the establishment of policies pertaining to the administration, management or provision of medical services; or

   3) the provision of operational support for the administration, management, or provision of medical services.

c. Entities which employ, contract with, or contract through any individual or entity that is excluded from Medicaid participation under Section 1128 or Section 1128A of the Act, for the provision of health care, utilization review, medical social work or administration services.

D. DISCLOSURE OF OWNERSHIP AND CONTROL INFORMATION

The CONTRACTOR agrees to meet the requirements of 42 CFR 455, Subpart B related to disclosure by the CONTRACTOR of ownership and control information.

E. SAFEGUARDING CONFIDENTIAL INFORMATION ON ENROLLEES

The CONTRACTOR agrees that information about Enrollees is confidential information and agrees to safeguard all confidential information and conform to the requirements set forth in 42CFR, Part 431, Subpart F as well as all other applicable Federal and State confidentiality requirements.

F. DISCLOSURE OF PROVIDER INCENTIVE PLANS

The CONTRACTOR must submit to the DEPARTMENT information on its physician incentive plans as listed in 42 CFR 417.479(h)(1) and summarized in this Article VII, Section F, Subsections 1 through 5, by May 1 of each year. The CONTRACTOR must provide to the DEPARTMENT the enrollee/disenrollee survey results when beneficiary surveys are required as specified in 42 CFR 417.479(g) and summarized in this Article VII, Section F, Subsection 7, by October 1 or three months after the end of the Contract year. The CONTRACTOR must submit to the DEPARTMENT information on capitation payments paid to primary care physicians as specified in 42 CFR 417.479(h)(1)(vi).

Per 42 CFR 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 Enrollee.

The CONTRACTOR may operate a physician incentive plan only if the stop-loss protection, Enrollee survey, and disclosure requirements are met. The CONTRACTOR must disclose to the DEPARTMENT the following information on provider incentive plans in sufficient detail to determine whether the incentive plan complies with the regulatory requirements. The disclosure must contain:

1. Whether services not furnished by the physician or physician group are covered by the incentive plan. If only the services furnished by the physician or physician group are covered by the incentive plan, disclosure of other aspects of the plan need not be made.

2. The type of incentive arrangement (i.e., withhold, bonus, capitation).

3. If the incentive plan involves a withhold or bonus, the percent of the withhold or bonus.

4. Proof that the physician or physician group has adequate stop-loss protection, including the amount and type of stop-loss protection.

5. The panel size and, if patients are pooled; the method used.

6. To the extent provided for in the Department of Health and Human Services, Centers for Medicare and Medicaid Services' (CMS) implementation guidelines, capitation payments paid to primary care physicians for the most recent year broken down by percent for primary care services, referral services to specialists, and hospital and other types of

provider services (i.e., nursing home and home health agency) for capitated physicians or physician groups.

7. In the case of those prepaid plans that are required to conduct beneficiary surveys, the survey results. (The CONTRACTOR must conduct a customer satisfaction of both Enrollees and disenrollees if any physicians or physicians groups contracting with the CONTRACTOR are placed at substantial financial risk for referral services. The survey must include either all current Enrollees and those who have disenrolled in the past twelve months, or a sample of these same Enrollees and disenrollees. Recognizing that different questions are asked of the disenrollees than those asked of Enrollees, the same survey cannot be used for both populations.)

The CONTRACTOR must disclose this information to the DEPARTMENT (1) prior to approval of its Contract or agreement and (2) upon the Contract or agreements anniversary or renewal effective date. The CONTRACTOR must provide the capitation data required (see 6 above) for the previous Contract year to the DEPARTMENT three months after the end of the Contract year. The CONTRACTOR will provide to the Enrollee upon request whether the CONTRACTOR uses a physician incentive plan that affects the use of referral services, the type of incentive arrangement, whether stop-loss protection is provided, and the survey results of any enrollee/disenrollee surveys conducted.

G. DEBARRED OR SUSPENDED INDIVIDUALS

Under Section 1921(d)(1) of the Social Security Act, the CONTRACTOR may not knowingly have a director, officer, partner, or person with beneficial ownership of more than 5% of the CONTRACTOR's equity who has been debarred or suspended by any federal agency. The CONTRACTOR may not have an employment, consulting, or any other agreement with a debarred or suspended person for the provision of items or services that are significant and material to meeting the provisions under this Contract.

The CONTRACTOR must certify to the DEPARTMENT that the requirements under Section 1921(d)(1) of the Social Security Act are met prior to the effective date of this Contract and at any time there is a change from the last such certification.

H. CMS CONSENT REQUIRED

If the Department of Health and Human Services, Centers for Medicare and Medicaid (CMS) directs the DEPARTMENT to terminate this Contract, the DEPARTMENT will not be permitted to renew this Contract without CMS consent.

ARTICLE VIII - PAYMENTS

A. RISK CONTRACT

This Contract is a risk contract as described in 42 CFR 447.361. Payments made to the CONTRACTOR may not exceed the cost to the DEPARTMENT of providing these same Covered Services on a fee-for-service basis, to an actuarially equivalent non-enrolled population.

B. PAYMENT AMOUNTS

1. PAYMENT SCHEDULE

On or before the 10th day of each month, the DEPARTMENT will pay to the CONTRACTOR the premiums due for each category shown for Enrollees for that month as determined by the DEPARTMENT from the Eligibility Transmission. Premiums shown in Attachment F-3 are based on rate negotiations between the CONTRACTOR and the DEPARTMENT.

2. CALCULATION OF PREMIUMS

The premiums do not include payment for recoupment of any previous losses incurred by the CONTRACTOR. The premiums established in this Contract will be prospectively set so as not to exceed the cost of providing the same Covered Services to an actuarially equivalent non-enrolled Medicaid population. The actuarially set fee-for-service equivalents developed by the DEPARTMENT are prospectively determined and conform with Federal guidelines as defined in CFR 447.361.

3. FEDERALLY QUALIFIED HEALTH CENTERS (FQHCs)

If the CONTRACTOR enters into a subcontract with a Federally Qualified Health Center (FQHC), the CONTRACTOR will reimburse the FQHC an amount not less than what the CONTRACTOR pays comparable providers that are not FQHCs.

4. TIME FRAME FOR REQUEST OF DELIVERY PAYMENT

The CONTRACTOR will submit a request for payment of the lump sum delivery amount within six months of the delivery date.

5. CONTRACT MAXIMUM

In no event will the aggregate amount of payments to the CONTRACTOR exceed the Contract maximum amount. If payments to the CONTRACTOR approach or exceed the Contract amount before the renewal date of the Contract, the DEPARTMENT shall execute a Contract amendment to increase the Contract amount within 30 calendar days of the date the Contract amount is exceeded.

C. MEDICARE

1. PAYMENT OF MEDICARE PART B PREMIUMS

The DEPARTMENT's will pay the Medicare Part B premium for each Enrollee who is on Medicare. The Enrollee will assign to the CONTRACTOR his or her Medicare reimbursement for benefits received under Medicare. The Eligibility Transmission includes and identifies those Enrollees who are covered under Medicare.

2. PAYMENT OF MEDICARE DEDUCTIBLE AND COINSURANCE

The DEPARTMENTs financial obligation under this Contract for Enrollees who are covered by both Medicare and the MCO is limited to the Medicare Part B premium and the CONTRACTOR premium. The CONTRACTOR is responsible for payment of the Medicare deductible and coinsurance for Enrollees when a service is paid for by Medicare whether or not the service is covered under this Contract. The CONTRACTOR is responsible for payment whether or not the Medicare covered service is rendered by a network provider or has been authorized by the CONTRACTOR. If a Medicare covered service is rendered by an out-of-network Medicare provider or a non-Medicare participating provider, the CONTRACTOR is responsible to pay for no more than the Medicare authorized amount. Attachment E, Table 2, will be used to identify the total cost to the CONTRACTOR of providing care for Enrollees who are also covered by Medicare.

3. MUST NOT BALANCE BILL ENROLLEES

The CONTRACTOR or its providers will not Balance Bill the Enrollee and will consider reimbursement from Medicare and from the CONTRACTOR as payment in full.

D. THIRD PARTY LIABILITY (COORDINATION OF BENEFITS)

The DEPARTMENT will provide the CONTRACTOR a monthly listing of Enrollees covered under the Buy-out Program, including the premium amount paid by the DEPARTMENT.

1. TPL COLLECTIONS

The CONTRACTOR will be responsible to coordinate benefits and collect third party liability (TPL). The CONTRACTOR will keep TPL collections. The DEPARTMENT will set rates net of expected TPL collections excluding the lump sum rate set for deliveries. The rate set for deliveries is the maximum amount the DEPARTMENT will pay the CONTRACTOR for each delivery. The CONTRACTOR must attempt to collect TPL before the DEPARTMENT will finalize payment for the lump sum delivery. The DHCF audit staff will monitor collections to ensure the CONTRACTOR is making a good faith effort to pursue TPL. The DEPARTMENT will properly account for TPL in its rate structure.

2. DUPLICATION OF BENEFITS

This provision applies when, under another health insurance plan such as a prepaid plan, insurance contract, mutual benefit association or employer's self-funded group health and welfare program, etc., an Enrollee is entitled to any benefits that would totally or partially duplicate the benefits that the CONTRACTOR is obligated to provide under this Contract. Duplication exists when (1) the CONTRACTOR has a duty to provide, arrange for or pay for the cost of Covered Services, and (2) another health insurance plan, pursuant to its own terms, has a duty to provide, arrange for or pay for the same type of Covered Services regardless of whether the duty of the CONTRACTOR is to provide the Covered Services and the duty of the other health insurance plan is only to pay for the Covered Services. Under State and Federal laws and regulations, Medicaid funds are the last dollar source and all other health insurance plans as referred to above are primarily responsible for the costs of providing Covered Services.

3. RECONCILIATION OF OTHER TPL

In order to assist the CONTRACTOR in billing and collecting from other health insurance plans the DEPARTMENT will include on the Eligibility Transmission other health insurance plans of each Enrollee when it is known. The CONTRACTOR will review the Eligibility Transmission and will report to the Office of Recovery Services or the DEPARTMENT any TPL discrepancies identified within 30 working days of receipt of the Eligibility Transmission. The CONTRACTOR's report will include a listing of Enrollees that the CONTRACTOR has independently identified as being covered by another health insurance plan.

4. WHEN TPL IS DENIED

On a monthly basis, the CONTRACTOR will report to the Office of Recovery Services (ORS) claims that have been billed to other health care plans but have been denied which will include the following information:

a. patient name and Medicaid identification number

b. ICD-9-CM code;

c. procedure codes; and

d. insurance company.

5. NOTIFICATION OF PERSONAL INJURY CASES

The CONTRACTOR will be responsible to notify ORS of all personal injury cases, as defined by ORS and agreed to by the CONTRACTOR, no later than 30 days after the

CONTRACTOR has received a "clean" claim. A clean claim is a claim that is ready to adjudicate. The following data elements will be provided by the CONTRACTOR to ORS:

a. patient name and Medicaid identification number

b. date of accident;

c. specific type of injury by ICD-9-CM code;

d. procedure codes; and

e. insurance company, if known.

6. ORS TO PURSUE COLLECTIONS

ORS will pursue collection on all claims described in Attachment B, Article VIII (Payments), Section D, Subsections 4 and 5 of this Contract. The DEPARTMENT will retain, for administrative costs, one third of the collections received for the period during which medical services were provided by the CONTRACTOR, and remit the balance to the CONTRACTOR.

7. INSURANCE BUY-OUT PROGRAM

The Insurance Buy-out Program is an optional program in which the DEPARTMENT purchases group health insurance for a recipient who is eligible for Medicaid when it is determined cost-effective for the Medicaid program to do so. The insurance buy-out process will be coordinated by the DEPARTMENT in cooperation with the Office of Recovery Services, and Medicaid eligibility workers. The following procedures regarding the buy-out program are:

a. the CONTRACTOR will file claims against group MCOs first before claiming services against the CONTRACTOR or other MCOs.

b. The DEPARTMENT will pay the CONTRACTOR a Medicaid premium for every buy-out Enrollee.

c. The DEPARTMENT will provide the CONTRACTOR a monthly listing of Enrollees covered under the Buy-out Program for the upcoming month.

d. On a quarterly basis, the Buy-out Program will bill the CONTRACTOR the lower of the Buy-out premium or the premium paid under this Contract when the Buy-out premium was paid to an entity other than the CONTRACTOR, i.e., the Buy-out premium is not a duplicate premium as defined in this Article VIII,

Section D, Item 7. The CONTRACTOR will remit to the Buy-out Program the amount billed within 60 days of receipt of the Buy-out bill.

8. CONTRACTOR MUST PAY PROVIDER ADMINISTRATIVE FEE FOR IMMUNIZATIONS

When an Enrollee has third party coverage for immunizations, the CONTRACTOR will pay the provider the administrative fee for providing the immunization and not require the provider to bill the third party as a cost avoidance method. The CONTRACTOR may choose to pursue the third party amount for the administrative fee after payment has been made to the provider.

E. THIRD PARTY RESPONSIBILITY (INCLUDING WORKER'S COMPENSATION)

1. CONTRACTOR TO BILL USUAL AND CUSTOMARY CHARGES

When a third party has an obligation to pay for Covered Services provided by the CONTRACTOR to an Enrollee pursuant to this Contract, the CONTRACTOR will bill the third party for the usual and customary charges for Covered Services provided and costs incurred. Should any sum be recovered by the Enrollee or otherwise, from or on behalf of the person responsible for payment for the service, the CONTRACTOR will be paid out of such recovery for the charges for service provided and costs incurred by the CONTRACTOR.

2. THIRD PARTY'S OBLIGATION TO PAY FOR COVERED SERVICES

Examples of situations where a third party has an obligation to pay for Covered Services provided by the CONTRACTOR are when (a) the Enrollee is injured by a person due to the negligent or intentional acts (or omissions) of the person; or (b) the Enrollee is eligible to receive payment through Worker's Compensation Insurance. If the Enrollee does not diligently seek such recovery, the CONTRACTOR may institute such rights that it may have.

3. FIRST DOLLAR COVERAGE FOR ACCIDENTS

In addition, both parties agree that the following will apply regarding first dollar coverage for accidents: if the injured party has additional insurance, primary coverage may be given to the motor insurance effective at the time of the accident. Once the motor vehicle policy is exhausted, the CONTRACTOR will be the secondary payer and pay for all of the Enrollee's Covered Services. If medical insurance does not exist, the CONTRACTOR will be the primary payer for all Covered Services.

4. NOTIFICATION OF STOP-LOSS

The CONTRACTOR will provide ORS with quarterly updates of costs incurred by the CONTRACTOR when such costs exceed Stop Loss (reinsurance) provisions as defined in the Contract between the reinsurer and the CONTRACTOR.

F. CHANGES IN COVERED SERVICES

If Covered Services are amended under the provisions of Attachment B, Article IV (Benefits), Section C, Subsection 3 of this Contract, rates may be renegotiated.

ARTICLE IX - RECORDS, REPORTS AND AUDITS

A. FEDERALLY REQUIRED REPORTS

1. CHEC/EPSDT REPORTS

The CONTRACTOR agrees to act as a continuing care provider for the CHEC/EPSDT program in compliance with OBRA '89 and Social Security Act Sections 1902(a)(43), 1905(a)(4)(B)and l905(r).

a. CHEC/EPSDT SCREENINGS

Annually, the CONTRACTOR will submit to the DEPARTMENT information on CHEC/EPSDT screenings to meet the Federal EPSDT reporting requirements (Form HCFA-416). The data will be in a mutually agreed upon format. The CHEC/EPSDT information is due December 31 for the prior federal fiscal year's data (October 1 through September 30).

b. IMMUNIZATION DATA

The CONTRACTOR will submit immunization data as part of the CHEC/EPSDT reporting. Enrollee name, Medicaid ID, type of immunization identified by procedure code, and date of immunization will be reported in the same format as the CHEC/EPSDT data.

2. DISCLOSURE OF PHYSICIAN INCENTIVE PLANS

The CONTRACTOR must submit to the DEPARTMENT information on its physician incentive plans as listed in 42 CFR 417.479(h)(1) [or Article VII - Other Requirements, F - Disclosure of Provider Incentive Plans, 1 through 5] by May 1 of each year. The CONTRACTOR must provide to the DEPARTMENT the enrollee/disenrollee survey

results when beneficiary surveys are required as specified in 42 CFR 417.479(g) [or #7 under Article VII.F.] by October 1 or three months after the end of the Contract year. The CONTRACTOR must submit to the DEPARTMENT information on capitation payments paid to primary care physicians as specified in 42 CFR 417.479(h)(1)(vi).

B. PERIODIC REPORTS

1. ENROLLMENT, COST AND UTILIZATION REPORTS (ATTACHMENT E)

Enrollment, cost and utilization reports will be submitted on diskettes in Excel or Lotus and in the format specified in Attachment E. A hard copy of the report must be submitted as well. The DEPARTMENT will send to the CONTRACTOR a template of the Attachment E format on a diskette. The CONTRACTOR may not customize or change the report format. The financial information for these reports will be reported as defined in HCFA Publication 75, and if applicable, HCFA 15-1. The CONTRACTOR will certify in writing the accuracy and completeness, to the best of its knowledge, of all costs and utilization data provided to the DEPARTMENT on Attachment E.

Two Attachment E reports will be submitted covering dates of service for each Contract year.

a. Attachment E is due May 1 for the preceding six-month reporting period (July through December).

b. Attachment E is due November 1 for the preceding 12-month reporting period (July through June).

If necessary, the CONTRACTOR may request, in writing, an extension of the due date up to 30 days beyond the required due date. The DEPARTMENT will approve or deny the extension request writing within seven calendar days of receiving the request.

2. INTERPRETIVE SERVICES

Annually, on November 1, the CONTRACTOR will submit summary information about the use of interpretive services during the previous Contract year (July 1 through June 30). The information must include the following, broken out by month and by county:

a. a list of all sources of interpreter services;

b. the total amount of time interpretive services were used broken out by clinical versus administrative;

c. total expenditures for each language;

d. total expenditures for clinical versus administrative;

e. number of Enrollees who used interpretive services for each language;

f. number of services provided by type of service within clinical versus administrative.

3. SEMI-ANNUAL REPORTS

The following semi-annual reports are due May 1 for the preceding six-month reporting period ending December 31 (July through December) and are due November 1 for the preceding six month period ending June 30 (January through June).

a. ORGAN TRANSPLANTS

A report of the total number of organ transplants by type of transplant.

b. OBSTETRICAL INFORMATION

A report of obstetrical information including

1) total number of obstetrical deliveries by aid category grouping;

2) total number of caesarean sections and total number of vaginal deliveries;

3) total number low birth weight infants; and

4) total number of Enrollees requiring prenatal hospital admission.

c. COMPLAINTS AND FORMAL GRIEVANCES

A summary of complaints and formal grievances, by type of complaint or grievance, received by the CONTRACTOR under this Contract and actions taken to resolve such complaints and grievances

d. ABERRANT PHYSICIAN BEHAVIOR

Summary information of corrective actions taken on physicians who have been identified by the CONTRACTOR as exhibiting aberrant physician behavior and the names of physicians who have been removed from the CONTRACTOR's network due to aberrant behavior. The summary shall include the reasons for the corrective action or removal.

4. QUALITY ASSURANCE ACTIVITIES

Annually, the CONTRACTOR will submit its written quality improvement plan, quality improvement work plan, and a report that identifies the CONTRACTOR's internal quality assurance activities, results thereof, and corrective actions taken during the previous year. These reports are due within three months of the CONTRACTOR's new year; i.e., by March 31 if on a calendar year.

5. HEDIS

Audited Health Plan Employer Data and Information Set (HEDIS) performance measures will cover services rendered during each calendar year and will be reported as set forth in State rule by the Office of Health Data Analysis. For example, calendar year 1997 HEDIS measures will be reported in 1998.

The CONTRACTOR must receive certification from an independent, credible vendor that its electronic submissions of encounter data are compliant with the Health Insurance Portability and Accountability Act (HIPAA) requirements. At a minimum, the CONTRACTOR must be HIPAA-compliant in the first four levels of HIPAA compliance: Level 1 - Integrity Testing, Level 2 - Requirement Testing, Level 3 - Balancing, and Level 4 - Situation Testing.

6. ENCOUNTER DATA

Encounter data, as defined in the DEPARTMENT's "Encounter Records Technical Manual," is due (including all replacements) six months after the end of the quarter being reported. Encounter data will be submitted in accordance with the instructions detailed in the Encounter Records Technical Manual for dates of service beginning July 1, 1996. The CONTRACTOR must receive certification from an independent, credible vendor that their electronic submissions of encounter data are compliant with the Health Insurance Portability and Accountability Act (HIPAA) requirements. At a minimum, the CONTRACTOR must be HIPAA-compliant in the first four levels of HIPAA compliance: Level 1 - Integrity Testing, Level 2 - Requirement Testing, Level 3 - Balancing, and Level 4 - Situation Testing.

7. DOCUMENTS DUE PRIOR TO QUALITY MONITORING REVIEWS

The following documents are due on request or at least 60 days prior to the DEPARTMENT's quality assurance monitoring review unless the DEPARTMENT has already received documents that are in effect:

a. the CONTRACTOR's most current (may be in draft stage) written plan for quality improvement;

b. the CONTRACTOR's most current (may be in draft stage) annual quality improvement work plan;

c. the CONTRACTOR's reports that identify over and under utilization of covered services and efforts put in place to resolve inappropriate over utilization and under utilization;

d. the CONTRACTOR's process for identifying and correcting aberrant provider behavior; and

e. other information requested by the DEPARTMENT to facilitate the DEPARTMENT's review of the CONTRACTOR's compliance to standards defined in the Division of Health Care Financing's MCO Quality Assurance Monitoring Plan (Attachment G).

The above documents must show evidence of a well defined, organized program designed to improve client care.

8. AUDIT OF ABORTIONS, STERILIZATIONS AND HYSTERECTOMIES

The CONTRACTOR must conduct an annual audit of all abortions in addition to an audit of a sample of sterilizations and hysterectomies as set by the DEPARTMENT that the CONTRACTOR's providers performed during each Contract year to assure compliance of its providers with all federal and state requirements related to federal financial participation of abortions.

On November 1 of each year, the CONTRACTOR will submit to the DEPARTMENT the following information on the results of the abortion, sterilization and hysterectomy audit for the previous calendar year. For the sterilization and hysterectomy audit, submit documentation of the methodology used to pull the sample of sterilization and hysterectomies and sampling proportions for each sample.

In an Excel file, submit the following information for all abortions, the sample of sterilizations, and the sample of hysterectomies:

- client name
- Medicaid ID number
- procedure code
- date of service
- history/physical (yes/no)
- operative report (yes/no)
- pathology report (yes/no)
- consent form (yes/no)

. medical necessity criteria - hysterectomies only

9. DEVELOPMENT OF NEW REPORTS

Any new reports/data requirements mandated by the DEPARTMENT will be mutually developed by the DEPARTMENT and the CONTRACTOR.

C. RECORD SYSTEM REQUIREMENTS

In accordance with Section 4752 of OBRA '90 (amended section 1903 (m)(2)(A) of the Social Security Act), the CONTRACTOR agrees to maintain sufficient patient encounter data to identify the physician who delivers Covered Services to Enrollees. The CONTRACTOR agrees to provide this encounter data, upon request of the DEPARTMENT, within 30 days of the request.

D. MEDICAL RECORDS

The CONTRACTOR agrees that medical records are considered confidential information and agrees to follow Federal and State confidentiality requirements.

The CONTRACTOR will require that its providers maintain a medical record keeping system through which all pertinent information relating to the medical management of the Enrollee is maintained, organized, and is readily available to appropriate professionals. Notwithstanding any other provision of this Contract to the contrary, medical records covering Enrollees will remain the property of the provider, and the provider will respect every Enrollee's privacy by restricting the use and disclosure of information in such records to purposes directly connected with the Enrollee's health care and administration of this Contract. The CONTRACTOR will use and disclose information pertaining to individual Enrollees and prospective Enrollees only for purposes directly connected with the administration of the Medicaid Program and this Contract.

E. AUDITS

1. RIGHT OF DEPARTMENT AND CMS TO AUDIT

The DEPARTMENT and the Department of Health and Human Services, Centers for Medicare and Medicaid Services may audit and inspect any financial records of the CONTRACTOR or its subcontractors relating (I) to the ability of the CONTRACTOR to bear the risk of potential financial losses, or (II) to evaluate services performed or determinations of amounts payable under the Contract.

2. INFORMATION TO DETERMINE ALLOWABLE COSTS

The CONTRACTOR will make available to the DEPARTMENT all reasonable and related financial, statistical, clinical or other information needed for the determination of allowable costs to the Medicaid program for "related party/home office" transactions as

defined in HCFA 15-1. These records are to be made available in Utah or the CONTRACTOR will pay the increased cost (incremental travel, per diem, etc.) of auditing at the out-of-state location. The cost to the CONTRACTOR will include round-trip travel and two days per diem/lodging. Additional travel costs of the site audit will be shared equally by the CONTRACTOR and the DEPARTMENT.

3. MANAGEMENT AND UTILIZATION AUDITS

The MCO will allow the DEPARTMENT and the Department of Health and Human Services, Centers for Medicare and Medicaid Services, to perform audits for identification and collection of management data, including Enrollee satisfaction data, quality of care data, fraud-related data, abuse-related data, patient outcome data, and cost and utilization data, which will include patient profiles, exception reports, etc. The CONTRACTOR will provide all data required by the DEPARTMENT or the independent quality review examiners in performance of these audits. Prior to beginning any audit, the DEPARTMENT will give the CONTRACTOR reasonable notice of audit, and the DEPARTMENT will be responsible for costs of its auditors or representatives.

F. INDEPENDENT QUALITY REVIEW

1. IN GENERAL

Pursuant to Section 1932(c)(2)(A) of the Social Security Act the DEPARTMENT will provide for an annual external independent review conducted by a qualified independent entity of the quality outcomes and timeliness of and access to Covered Services. The CONTRACTOR will support the annual external independent review.

The DEPARTMENT will choose an agency to perform an annual independent quality review pursuant to federal law and will pay for such review. The CONTRACTOR will maintain all clinical and administrative records for use by the quality review contractor.

The CONTRACTOR agrees to support quality assurance reviews, focused studies and other projects performed for the DEPARTMENT by the external quality review organization (EQRO). The purpose of the reviews and studies are to comply with federal requirements for an annual independent audit of the quality outcomes and timeliness of, and access to, Covered Services. The external independent reviews are conducted by the EQRO, with the advice, assistance, and cooperation of a planning team composed of representatives from the CONTRACTOR, the EQRO and the DEPARTMENT with final approval by the DEPARTMENT.

2. SPECIFIC REQUIREMENTS

a. LIAISON FOR ROUTINE COMMUNICATION

The CONTRACTOR will designate an individual to serve as liaison with the EQRO for routine communication with the EQRO.

b. REPRESENTATIVE TO ASSIST WITH PROJECTS

The CONTRACTOR will designate a minimum of two representatives (unless one individual can service both functions) to serve on the planning team for each EQRO project. Representatives will include a quality improvement representative and a data representative. The planning team is a joint collaborative forum between DEPARTMENT staff, the EQRO and the CONTRACTOR. The role of the planning team is to participate in the process and completion of EQRO projects.

c. COPIES AND ON-SITE ACCESS

The CONTRACTOR will be responsible for obtaining copies of Enrollee information and facilitating on-site access to Enrollee information as needed by the EQRO. Such information will be used to plan and conduct projects and to investigate complaints and grievances. Any associated copying costs are the responsibility of the CONTRACTOR. Enrollee information includes medical records, administrative data such as, but not limited to, enrollment information and claims, nurses' notes, medical logs, etc. of the CONTRACTOR or its providers.

d. FORMAT OF ENROLLEE FILES

The CONTRACTOR will provide Enrollee information in a mutually agreed upon format compatible for the EQRO's use, and in a timely fashion to allow the EQRO to select cases for its review.

e. TIME-FRAME FOR PROVIDING DATA

The CONTRACTOR will provide data requests to the EQRO within 15 Working days of the written request from the EQRO and will provide medical records within 30 working days of the written request from the EQRO. Requests for extensions of these time frames will be reviewed and approved or disapproved by the DEPARTMENT on a case-by-case basis.

f. WORK SPACE FOR ON-SITE REVIEWS

The CONTRACTOR will assure that the EQRO staff and consultants have adequate work space, access to a telephone and copy machines at the time of review. The review will be performed during agreed-upon hours.

g. STAFF ASSISTANCE DURING ON-SITE VISITS

The CONTRACTOR will assign appropriate person(s) to assist the EQRO personnel conduct the reviews during on-site visits and to participate in an informal discussion of screening observations at the end of each on-site visit, if necessary.

h. CONFIDENTIALITY

For information received from the EQRO, the CONTRACTOR will comply with the Department of Health and Human Services regulations relating to confidentiality of data and information (42 CFR Part 476.107 and 476.108).

ARTICLE X - SANCTIONS

The DEPARTMENT may impose intermediate sanctions on the CONTRACTOR if the CONTRACTOR defaults in any manner in the performance of any obligation under this Contract including but not limited to the following situations:

(1) the CONTRACTOR fails to substantially provide Medically Necessary Covered Services to Enrollees;

(2) the CONTRACTOR imposes premiums or charges Enrollees in excess of the premiums or charges permitted under this Contract;

(3) the CONTRACTOR acts to discriminate among Enrollees on the basis of their health status or requirements for health care services, including expulsion or refusal to re-enroll an individual, except as permitted by Title XIX, or engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment with the MCO by potential Enrollees whose medical condition or history indicates a need for substantial future medical services;

(4) the CONTRACTOR misrepresents or falsifies information furnished to the Department of Health and Human Services, Centers for Medicare and Medicaid Services, the DEPARTMENT, an Enrollee, potential Enrollee or health care provider;

(5) the CONTRACTOR fails to comply with the physician incentive requirements under Section 1903(m)(2)(A)(x) of the Social Security Act.

(6) the CONTRACTOR distributed directly or through any agent or independent contractor marketing materials that contain false or misleading information.

The DEPARTMENT must follow the 1997 Balance Budget Act guidelines on the types of

intermediate sanctions the DEPARTMENT may impose, including civil monetary penalties, the appointment of temporary management, and suspension of payment.

ARTICLE XI - TERMINATION OF THE CONTRACT

A. AUTOMATIC TERMINATION

This Contract will automatically terminate June 30, 2004.

B. OPTIONAL YEAR-END TERMINATION

At the end of each Contract year, either party may terminate the Contract without cause for subsequent years by giving the other party written notice of termination at least 90 days prior to the end of the Contract year (July 1 through June 30).

C. TERMINATION FOR FAILURE TO AGREE UPON RATES

At least 60 days prior to the end of each Contract year, the parties will meet and negotiate in good faith the rates (Attachment F) applicable to the upcoming year. If the parties cannot agree upon future rates by the end of the Contract year, then either party may terminate the Contract for subsequent years by giving the other party written notice of termination and the termination will become effective 90 days after receipt of the written notice of termination.

D. EFFECT OF TERMINATION

1. COVERAGE

In as much as the CONTRACTOR is paid on a monthly basis, the CONTRACTOR will continue providing the Covered Services required by this Contract until midnight of the last day of the calendar month in which the termination becomes effective. If an Enrollee is a patient in an inpatient hospital setting during the month in which termination becomes effective, the CONTRACTOR is responsible for the entire hospital stay including physician charges until discharge or thirty days following termination, whichever occurs first.

2. ENROLLEE NOT LIABLE FOR DEBTS OF CONTRACTOR OR ITS SUBCONTRACTORS

If the CONTRACTOR or one of its subcontractors becomes insolvent or bankrupt, the Enrollees will not be liable for the debts of the CONTRACTOR or its subcontractor. The CONTRACTOR will include this term in all of its subcontracts.

3. INFORMATION FOR CLAIMS PAYMENT

The CONTRACTOR will promptly supply to the DEPARTMENT all information necessary for the reimbursement of any Medicaid claims not paid by the CONTRACTOR.

4. CHANGES IN ENROLLMENT PROCESS

The CONTRACTOR will be advised of anticipated changes in policies and procedures as they relate to the enrollment process and their comments will be solicited. The CONTRACTOR agrees to be bound by such changes in policies and procedures unless they are not agreeable to the CONTRACTOR, in which case the CONTRACTOR may terminate the Contract in accordance with the Contract termination provisions.

5. HEARING PRIOR TO TERMINATION

Regarding the General Provisions, Article XVII (Default, Termination, & Payment Adjustment), item 3, if the CONTRACTOR fails to meet the requirements of the Contract, the DEPARTMENT must give the CONTRACTOR a hearing prior to termination. Enrollees must be informed of the hearing and will be allowed to disenroll from the MCO without cause.

E. ASSIGNMENT

Assignment of any or all rights or obligations under this Contract without the prior written consent of the DEPARTMENT is prohibited. Sale of all or any part of the rights or obligations under this Contract will be deemed an assignment. Consent may be withheld in the DEPARTMENT's sole and absolute discretion.

ARTICLE XII - MISCELLANEOUS

A. INTEGRATION

This Contract contains the entire agreement between the parties with respect to the subject matter of this Contract. There are no representations, warranties, understandings, or agreements other than those expressly set forth herein. Previous contracts between the parties hereto and conduct between the parties which precedes the implementation of this Contract will not be used as a guide to the interpretation or enforcement of this Contract or any provision hereof.

B. ENROLLEES MAY NOT ENFORCE CONTRACT

Although this Contract relates to the provision of benefits for Enrollees and others, no Enrollee is entitled to enforce any provision of this Contract against the CONTRACTOR nor will any provision of this Contract be constructed to constitute a promise by the CONTRACTOR to any Enrollee or potential Enrollee.

C. INTERPRETATION OF LAWS AND REGULATIONS

The DEPARTMENT will be responsible for the interpretation of all federal and State laws and regulations governing or in any way affecting this Contract. When interpretations are required, the CONTRACTOR will submit written requests to the DEPARTMENT. The DEPARTMENT will retain full authority and responsibility for the administration of the Medicaid program in accordance with the requirements of Federal and State law.

D. ADOPTION OF RULES

Adoption of rules by the DEPARTMENT, subsequent to this amendment, and which govern the Medicaid program, will be automatically incorporated into this Contract upon receipt by the CONTRACTOR of written notice thereof.

ARTICLE XIII - EFFECT OF GENERAL PROVISIONS

If there is a conflict between these Special Provisions (Attachment B) or the General Provisions (Attachment A), then these Special Provisions will control.

AFC/MOLINA

URBAN & RURAL RATES AND RATE-RELATED TERMS
Effective July 1,2001

A. PREMIUM RATES

1. URBAN MONTHLY PREMIUM RATES BASED ON ENROLLEES' RATE CELLS

Age 0 to l	TANF Male 1 to 21	TANF Male 21 & Over	TANF Female 1 to 21	TANF Female 21 & Over	Aged
$ [*]	$ [*]	$ [*]	$ [*]	$ [*]	$ [*]

Disabled Male	Disabled Female	Medically Needy Child	Medically Needy Adult	Non TANF Pregnant F	BCC	Restriction Program
$ [*]	$ [*]	$ [*]	$ [*]	$ [*]	$ [*]	$ [*]

2. RURAL MONTHLY PREMIUM RATES BASED ON ENROLLEES' RATE CELLS

Age 0 to l	TANF Male 1 to 21	TANF Male 21 & Over	TANF Female 1 to 21	TANF Female 21 & Over	Aged
$ [*]	$ [*]	$ [*]	$ [*]	$ [*]	$ [*]

Disabled Male	Disabled Female	Medically Needy Child	Medically Needy Adult	Non TANF Pregnant F	BCC	Restriction Program
$ [*]	$ [*]	$ [*]	$ [*]	$ [*]	$ [*]	$ [*]

3. SPECIAL RATE

An AIDS rate of $ [*] per month will be paid in addition to the regular monthly premium when the T-Cell count is below 200.

B. PER DELIVERY REIMBURSEMENT SCHEDULE

The DEPARTMENT shall reimburse the CONTRACTOR $ [*] per delivery to cover all Medically Necessary antepartum care, delivery, and postpartum professional, facility and ancillary services. The monthly premium amount for the enrollee is in addition to the delivery fee. The delivery payment will be made when the delivery occurs at 22 weeks or later, regardless of viability.

C. CHEC SCREENING INCENTIVE CLAUSE

1. CHEC SCREENING GOAL

The CONTRACTOR will ensure that Medicaid children have access to appropriate well-child visits. The CONTRACTOR will follow the Utah EPSDT (CHEC) guidelines for the periodicity schedule for well-child protocol. The federal agency, Health Care Financing Administration, mandates that all states have 80% of all children screened. The DEPARTMENT and the CONTRACTOR will work toward that goal.

2. CALCULATION OF CHEC INCENTIVE PAYMENT

The DEPARTMENT will calculate the CONTRACTOR's annual participation rate based on information supplied by the CONTRACTOR under the HCFA-416 EPSDT (CHEC) reporting requirements. Based on the HCFA-416 data, the CONTRACTOR's well-child participation rate was 100% for Federal Fiscal Year (FFY) 2000 (October 1999 through September 2000). The incentive payment for the contract year ending June 30, 2002 will be based on the CONTRACTOR's FFY 2001 (October 1, 2000 through September 30, 2001) HCFA-416 participation rate. The DEPARTMENT will pay the CONTRACTOR $ [*] if a rate of 90% or higher is maintained during FFY 2001. The participation rate will be calculated no later than April 15, 2002; the CONTRACTOR will be notified of the incentive payment, if applicable, no later than April 30, 2002.

3. CONTRACTOR's USE OF INCENTIVE PAYMENT

The CONTRACTOR agrees to use this incentive payment to reward the CONTRACTOR's employees responsible for improving the EPSDT (CHEC) participation rate.

D. IMMUNIZATION INCENTIVE CLAUSE

The CONTRACTOR will ensure that Enrollees have access to recommended immunizations.
The CONTRACTOR will follow the Advisory Committee on Immunization Practices'

recommendations for immunizations for children.

1. IMMUNIZATIONS FOR TWO-YEAR-OLDS

Utah has achieved a statewide immunization level of 76% for two-year-olds. The average Medicaid HMO rate was 53.2% for the 1999 HEDIS Combination 1 immunization measure for two-year-olds.

Based on the CONTRACTOR's 2000 HEDIS measure for the Combination I immunization for two-year-olds, the DEPARTMENT will pay the CONTRACTOR $ [*] for each full percentage point above 53.2%.

2. IMMUNIZATIONS FOR ADOLESCENTS

The DEPARTMENT realizes it is important that adolescents are vaccinated according to schedule as recommended by the Advisory Committee on Immunization Practices. The average Medicaid HMO rate was 3.7% for the 1999 HEDIS Combination I immunization measure for adolescents.

Based on the CONTRACTOR's 2000 HEDIS measure for adolescent immunizations, the DEPARTMENT will pay the CONTRACTOR $ [*] for each full percentage point above 3.7% up to 53.7%.

3. IMMUNIZATIONS FOR ADULTS

The HEDIS immunization measure for adults is not reported for Medicaid clients age 65 and older. The DEPARTMENT intends to expand this incentive clause to include improved immunization rates for influenza and pneumonia vaccines among Enrollees age 65 and older. The DEPARTMENT will work with contractors to collect this data during this Contract year (July 1, 2001 - June 30, 2002).

4. CONTRACTOR's USE OF INCENTIVE PAYMENT

The CONTRACTOR agrees to use this incentive payment to reward the CONTRACTOR's employees responsible for improving the HEDIS immunization measures.

E. REINSURANCE POLICY

Reinsurance will be administered by a reinsurer, Centre Insurance Company.

Costs, net of TPL, for all inpatient and outpatient services listed in Attachment C that are covered on the date of service rendered and incurred from July 1, 2001 through June 30, 2002 by the

MCO for an Enrollee shall be shared by Centre Insurance Company under the following conditions:

1. the date of service is from July 1, 2001 through June 30, 2002 (based on date of discharge if inpatient hospital stay);

2. paid claims incurred by the MCO exceed $50,000; and

3. services shall have been incurred by the MCO during the time the client is enrolled with the MCO.

   If the above conditions are met, Centre Insurance Company shall bear [*]% and the MCO shall bear [*]% of the amount that exceeds $50,000.

F. REIMBURSEMENT FOR REINSURANCE

The CONTRACTOR agrees to purchase reinsurance from Centre Insurance Company at the per Enrollee per month rate negotiated by the DEPARTMENT and the reinsurer. The DEPARTMENT will reimburse the CONTRACTOR for its premium payments to Centre Insurance Company. In addition, the DEPARTMENT will pay the CONTRACTOR $ [*] per Enrollee per month to cover reinsurance administrative costs.

Beginning July 1, 2001, the DEPARTMENT will make monthly payments to the CONTRACTOR based on the reinsurance premiums the CONTRACTOR pays to Centre Insurance Company. The DEPARTMENT will calculate the reinsurance premiums using the DEPARTMENT's data on the number of Enrollees.

G. RETROSPECTIVE ADJUSTMENT

The DEPARTMENT agrees to retroactively adjust annual payments to the CONTRACTOR under this Contract for Enrollees who qualify for Medicaid due to a diagnosis of breast cancer or cervical cancer.

If the CONTRACTOR's claim expenditures for Enrollees in the Breast/ Cervical Cancer (BCC) rate cell exceed the premiums plus other BCC payments, the DEPARTMENT will reimburse the CONTRACTOR for the unrecovered costs related to BCC claim expenditures. Claim contract payments include reinsurance and TPL payments. Therefore, paid claim expenditures will also include reinsurance (stop-loss) claims paid by the CONTRACTOR for BCC Enrollees.

If the CONTRACTOR's claim expenditures for BCC Enrollees are less than the BCC premiums paid plus other BCC contract payments, the CONTRACTOR can retain up to [*]% of the excess premiums and other payments paid for BCC Enrollees. If there are additional savings after the

CONTRACTOR has recovered the [*]%, the excess premium and other payment amounts for BCC Enrollees will be reimbursed to the DEPARTMENT. Claim contract payments include reinsurance and TPL payments. Therefore, paid claims expenditures will also include reinsurance (stop-loss) claims paid by the CONTRACTOR for BCC Enrollees.

The CONTRACTOR shall submit to the DEPARTMENT a request for this retrospective adjustment no later than six months after the close of the contract year. agrees to use its Medicaid payment rates and fee schedules used to price their Medicaid product as a basis for the retrospective adjustment calculation.

UTAH DEPARTMENT OF HEALTH
288 North 1460 West, Salt Lake City, Utah 84116

CONTRACT AMENDMENT

H992020205-04	006146
Department Log Number	State Contract Number

1. CONTRACT NAME:
   The name of this Contract is HMO-AFC/MOLINA, the Contract number assigned by the State Division of Finance is 006146, the Contract number assigned by the Utah Department of Health is H992020205, and this Amendment is number 4.

2. CONTRACTING PARTIES:
   This Contract Amendment is between the Utah Department of Health (DEPARTMENT), and Molina Healthcare of Utah (CONTRACTOR).

3. PURPOSE OF CONTRACT AMENDMENT:
   To change the rates effective November 1, 2001 due to the co-payment policy; to change the rates effective February 1, 2002 due to the co-insurance policy; and to replace the reinsurance provision with stop-loss provision.

4. CHANGES TO CONTRACT:
   A. Effective July 1, 2001, under Attachment E, Medical Services Revenue and Cost Definitions for Table 2, replace the language in items 3, 4, 54, 55, and 56 with the following:

      1. On Page 4 of Attachment E, under Revenue, replace item 3, Reinsurance, as follows:
         "Report the reinsurance payments received or receivable from a reinsurance carrier other than the DEPARTMENT."
      2. On Page 4 of Attachment E, under Revenue, replace item 4, Stop Loss, as follows:
         "Report stop loss payments received or receivable from the DEPARTMENT."
      3. On Page 9 of Attachment E, under Other Data, replace item 54, Reinsurance Premiums Received, as follows:
         "Include the reinsurance premiums received or receivable that are not counted as revenue."
      4. On Page 9 of Attachment E, under Other Data, replace item 55, Reinsurance Premiums Paid, as follows:
         "Include reinsurance premiums paid to a reinsurance carrier other than the DEPARTMENT."
      5. On Page 9 of Attachment E, under Other Data, replace item 56, Administrative Revenue Retained by the CONTRACTOR, as follows:
         "Include the administrative revenue retained by the CONTRACTOR from the reinsurance premiums received or receivable."

   B. Effective July 1, 2001, replace Attachment F - Urban and Rural Rates with Rate-Related Terms with Attachment F - Urban and Rural Rates and Rate-Related Terms as attached to this Amendment #4.

   C. All other provisions of the Contract remain unchanged.

5. If the Contractor is not a local public procurement unit as defined by the Utah Procurement Code (UCA Section 63-56-5), this Contract Amendment must be signed by a representative of the State Division of Finance and the State Division of Purchasing to bind the State and the Department to this Contract Amendment.

6. This Contract, its attachments, and all documents incorporated by reference constitute the entire agreement between the parties and supercede all prior negotiations, representations, or agreements, either written or oral between the parties relating to the subject matter of this Contract.

UTAH DEPARTMENT OF HEALTH
288 North 1460 West, Salt Lake City. Utah 84116

CONTRACT AMENDMENT

H992020205-04	00-6146
Department Log Number	State Contract Number

IN WITNESS WHEREOF, the parties sign this Contract Amendment.

CONTRACTOR: Molina Healthcare of Utah   UTAH DEPARTMENT OF HEALTH

By: /s/ Kirk Olsen	13 Mar 2002	By: /s/ Shari A. Watkins	4/03/02
Signature of Authorized Individual	Date	Shari A. Watkins, C.P.A. Director Office Of Fiscal Operations	Date

Print Name: Kirk Olsen

Title: Chief Executive Officer	[SEAL]	4/17/02
	State Finance:	Date
33-0617992	[ILLEGIBLE]	APR 18 2002
Federal Tax Identification Number or Social Security Number	State Purchasing:	Date

AFC/MOLINA
URBAN & RURAL RATES AND RATE-RELATED TERMS

A. PREMIUM RATES

1. URBAN MONTHLY PREMIUM RATES BASED ON ENROLLEES' RATE CELLS (EFFECTIVE JULY 1, 2001 THROUGH OCTOBER 31, 2001)

Age 0 to 1	TANF Male 1 to 21	TANF Male 21 & Over	TANF Female 1 to 21	TANF Female 21 & Over	Aged
$ [*]	$ [*]	$ [*]	$ [*]	$ [*]	$ [*]

Disabled Male	Disabled Female	Medically Needy Child	Medically Needy Adult	Non TANF Pregnant F	BCC	Restriction Program
$ [*]	$ [*]	$ [*]	$ [*]	$ [*]	$ [*]	$ [*]

2. URBAN MONTHLY PREMIUM RATES BASED ON ENROLLEES' RATE CELLS (EFFECTIVE NOVEMBER 1, 2001 THROUGH JANUARY 31, 2002)

Age 0 to 1	TANF Male 1 to 21	TANF Male 21 & Over	TANF Female 1 to 21	TANF Female 21 & Over	Aged
$ [*]	$ [*]	$ [*]	$ [*]	$ [*]	$ [*]

Disabled Male	Disabled Female	Medically Needy Child	Medically Needy Adult	Non TANF Pregnant F	BCC	Restriction Program
$ [*]	$ [*]	$ [*]	$ [*]	$ [*]	$ [*]	$ [*]

3. URBAN MONTHLY PREMIUM RATES BASED ON ENROLLEES' RATE CELLS (EFFECTIVE FEBRUARY 1, 2002 THROUGH JUNE 30, 2002)

Age 0 to 1	TANF Male 1 to 21	TANF Male 21 & Over	TANF Female 1 to 21	TANF Female 21 & Over	Aged
$ [*]	$ [*]	$ [*]	$ [*]	$ [*]	$ [*]

Disabled Male	Disabled Female	Medically Needy Child	Medically Needy Adult	Non TANF Pregnant F	BCC	Restriction Program
$ [*]	$ [*]	$ [*]	$ [*]	$ [*]	$ [*]	$ [*]

4. RURAL MONTHLY PREMIUM RATES BASED ON ENROLLEES' RATE CELLS (EFFECTIVE JULY 1, 2001 THROUGH OCTOBER 31, 2001)

Age 0 to 1	TANF Male 1 to 21	TANF Male 21 & Over	TANF Female 1 to 21	TANF Female 21 & Over	Aged
$ [*]	$ [*]	$ [*]	$ [*]	$ [*]	$ [*]

Disabled Male	Disabled Female	Medically Needy Child	Medically Needy Adult	Non TANF Pregnant F	BCC	Restriction Program
$ [*]	$ [*]	$ [*]	$ [*]	$ [*]	$ [*]	$ [*]

5. RURAL MONTHLY PREMIUM RATES BASED ON ENROLLEES' RATE CELLS (EFFECTIVE NOVEMBER 1, 2001 THROUGH JANUARY 31, 2002)

Age 0 to 1	TANF Male 1 to 21	TANF Male 21 & Over	TANF Female 1 to 21	TANF Female 21 & Over	Aged
$ [*]	$ [*]	$ [*]	$ [*]	$ [*]	$ [*]

Disabled Male	Disabled Female	Medically Needy Child	Medically Needy Adult	Non TANF Pregnant F	BCC	Restriction Program
$ [*]	$ [*]	$ [*]	$ [*]	$ [*]	$ [*]	$ [*]

6. RURAL MONTHLY PREMIUM RATES BASED ON ENROLLEES' RATE CELLS (EFFECTIVE FEBRUARY 1, 2002 THROUGH JUNE 30, 2002)

Age 0 to 1	TANF Male 1 to 21	TANF Male 21 & Over	TANF Female 1 to 21	TANF Female 21 & Over	Aged
$ [*]	$ [*]	$ [*]	$ [*]	$ [*]	$ [*]

Disabled Male	Disabled Female	Medically Needy Child	Medically Needy Adult	Non TANF Pregnant F	BCC	Restriction Program
$ [*]	$ [*]	$ [*]	$ [*]	$ [*]	$ [*]	$ [*]

7. SPECIAL RATE

An AIDS rate of $ [*] per month will be paid in addition to the regular monthly premium when the T-Cell count is below 200.

B. PER DELIVERY REIMBURSEMENT SCHEDULE

The DEPARTMENT shall reimburse the CONTRACTOR $ [*] per delivery to cover all Medically Necessary antepartum care, delivery, and postpartum professional, facility and ancillary services. The monthly premium amount for the enrollee is in addition to the delivery fee. The delivery payment will be made when the delivery occurs at 22 weeks or later, regardless of viability.

C. CHEC SCREENING INCENTIVE CLAUSE

1. CHEC SCREENING GOAL

The CONTRACTOR will ensure that Medicaid children have access to appropriate well-child visits. The CONTRACTOR will follow the Utah EPSDT (CHEC) guidelines for the periodicity schedule for well-child protocol. The federal agency, Centers for Medicare and Medicaid Services (CMS), mandates that all states have 80% of all children screened. The DEPARTMENT and the CONTRACTOR will work toward that goal.

2. CALCULATION OF CHEC INCENTIVE PAYMENT

The DEPARTMENT will calculate the CONTRACTOR's annual participation rate based on information supplied by the CONTRACTOR under the CMS-416 EPSDT (CHEC) reporting requirements. Based on the CMS-416 data, the CONTRACTOR's well-child participation rate was 100% for Federal Fiscal Year (FFY) 2000 (October 1999 through September 2000). The incentive payment for the Contract year ending June 30, 2002 will be based on the CONTRACTOR's FFY 2001 (October 1, 2000 through September 30, 2001) CMS-416 participation rate. The DEPARTMENT will pay the CONTRACTOR $ [*] if a rate of 90% or higher is maintained during FFY 2001. The participation rate will be calculated no later than April 15, 2002; the CONTRACTOR will be notified of the incentive payment, if applicable, no later than April 30, 2002.

3. CONTRACTOR's USE OF INCENTIVE PAYMENT

The CONTRACTOR agrees to use this incentive payment to reward the CONTRACTOR's employees responsible for improving the EPSDT (CHEC) participation rate.

D. IMMUNIZATION INCENTIVE CLAUSE

The CONTRACTOR will ensure that Enrollees have access to recommended immunizations. The CONTRACTOR will follow the Advisory Committee on Immunization Practices recommendations for immunizations for children.

1. IMMUNIZATIONS FOR TWO-YEAR-OLDS

Utah has achieved a statewide immunization level of 76% for two-year-olds. The average Medicaid HMO rate was 53.2% for the 1999 HEDIS Combination 1 immunization measure for two-year-olds.

Based on the CONTRACTOR's 2000 HEDIS measure for the Combination I immunization for two-year-olds, the DEPARTMENT will pay the CONTRACTOR $ [*] for each full percentage point above 53.2%.

2. IMMUNIZATIONS FOR ADOLESCENTS

The DEPARTMENT realizes it is important that adolescents are vaccinated according to schedule as recommended by the Advisory Committee on Immunization Practices. The average Medicaid HMO rate was 3.7% for the 1999 HEDIS Combination I immunization measure for adolescents.

Based on the CONTRACTOR's 2000 HEDIS measure for adolescent immunizations, the DEPARTMENT will pay the CONTRACTOR $ [*] for each full percentage point above 3.7% up to 53.7%.

3. IMMUNIZATIONS FOR ADULTS

The HEDIS immunization measure for adults is not reported for Medicaid clients age 65 and older. The DEPARTMENT intends to expand this incentive clause to include improved immunization rates for influenza and pneumonia vaccines among Enrollees age 65 and older. The DEPARTMENT will work with contractors to collect this data during this Contract year (July 1, 2001 - June 30, 2002).

4. CONTRACTOR's USE OF INCENTIVE PAYMENT

The CONTRACTOR agrees to use this incentive payment to reward the CONTRACTOR's employees responsible for improving the HEDIS immunization measures.

E. STOP LOSS

1. Costs, net of TPL, for all inpatient and outpatient services listed in Attachment C that are covered on the date of service rendered and incurred from July 1, 2001 through June 30, 2002 by the MCO for an Enrollee shall be shared by the DEPARTMENT under the following conditions:

   a. the date of service is from July 1, 2001 through June 30, 2002;

   b. inpatient claims that overlap years will be prorated to each contract year, based on patient days:

   c. paid claims incurred by the MCO exceed $50,000.00;

   d. services shall have been incurred by the MCO during the time the client is enrolled with the MCO;

   e. the stop-loss billing must be in a format mutually agreed upon and must include, at a minimum. Enrollee Medicaid identification number, date of birth, type of service, beginning date of service, ending date of service, billed charge. HMO payment, third party liability (TPL) collected, and primary diagnosis:

f. stop-loss billing must be submitted to the DEPARTMENT within seven months of the end of the Contract year;

If the above conditions are met, the DEPARTMENT shall bear 80% and the MCO shall bear 20% of the amount that exceeds $ [*] The maximum amount the DEPARTMENT will reimburse the CONTRACTOR under the stop-loss provision is $ [*] per Enrollee per Contract year.

2. PAYMENT OF STOP-LOSS

The DEPARTMENT will make interim payments to the CONTRACTOR equal to 90% of the expected payment pending an audit of the stop-loss claims submitted by the CONTRACTOR.

The DEPARTMENT will calculate the actual stop-loss amount due to the CONTRACTOR by July 1, 2003. The final settlement will be based on an audit conducted by the DEPARTMENT. The allowed payment for inpatient hospital stop-loss claims will be limited to 90% of the Medicaid fee schedule when the claim is from a related hospital as defined by CMS Pub. 15-I.

F. RETROSPECTIVE ADJUSTMENT

The DEPARTMENT agrees to retroactively adjust annual payments to the CONTRACTOR under this contract for Enrollees who qualify for Medicaid due to a diagnosis of breast cancer or cervical cancer.

If the CONTRACTOR's claim expenditures for Enrollees in the Breast/ Cervical Cancer (BCC) rate cell exceed the premiums plus other BCC payments, the DEPARTMENT will reimburse the CONTRACTOR for the unrecovered costs related to BCC claim expenditures. Claim contract payments include reinsurance and TPL payments.

If the CONTRACTOR's claim expenditures for BCC Enrollees are less than the BCC premiums paid plus other BCC contract payments, the CONTRACTOR can retain up to 10% of the excess premiums and other payments paid for BCC Enrollees. If there are additional savings after the CONTRACTOR has recovered the 10%, the excess premium and other payment amounts for BCC Enrollees will be reimbursed to the DEPARTMENT. Claim contract payments include reinsurance and TPL payments.

The CONTRACTOR shall submit to the DEPARTMENT a request for this retrospective adjustment no later than six months after the close of the Contract year. The CONTRACTOR agrees to use its Medicaid payment rates and fee schedules used to price their Medicaid product as a basis for the retrospective adjustment calculation.

UTAH DEPARTMENT OF HEALTH
288 North 1460 West, Salt Lake City. Utah 84116

CONTRACT AMENDMENT

H9920205-05	006146
Department Log Number	State Contract Number

1. CONTRACT NAME:
The name of this Contract is HMO-AFC/MOLINA, the Contract number assigned by the State Division of Finance is 006146, the Contract number assigned by the Utah Department of Health is H9920205, and this Amendment is number 5.

2. CONTRACTING PARTIES:
This Contract Amendment is between the Utah Department of Health (DEPARTMENT), and Molina Healthcare of Utah (CONTRACTOR).

3 PURPOSE OF CONTRACT AMENDMENT:
The purpose is to increase the maximum Contract Amount.

4. CHANGES TO CONTRACT:
A. On Page 1, Paragraph 4, CONTRACT AMOUNT, is changed to read as follows: "The Contractor will be paid up to a maximum amount of $[*] for the Contract Period in accordance with the provisions in this Contract. This Contract is funded with 70% Federal funds and 30% State funds. The CFDA # is 93.778 and relates to the federal funds provided."

B. All other provisions of the Contract remain unchanged.

5. If the Contractor is not a local public procurement unit as defined by the Utah Procurement Code (UCA Section 63-56-5), this Contract Amendment must be signed by a representative of the State Division of Finance and the State Division of Purchasing to bind the State and the Department to this Contract Amendment.

6. This Contract, its attachments, and all documents incorporated by reference constitute the entire agreement between the parties and supercede all prior negotiations, representations, or agreements, either written or oral between the parties relating to the subject matter of this Contract.

IN WITNESS WHEREOF, the parties sign this Contract Amendment.

CONTRACTOR: Molina Healthcare of Utah		UTAH DEPARTMENT OF HEALTH	
By: /s/ G. K. Olsen	8-8-02	By: /s/	8/9/02
Signature of Authorized Individual	Date	Shari A. Watkins, C.P.A. Director Office of Fiscal Operations	Date
Print Name: Kirk Olsen		CONTRACT RECEIVED AND PROCESSED BY DIVISION OF FINANCE	AUG 12 2002
		State Finance:	Date
Title: Chief Executive Officer			
33-0617992		/s/ [ILLEGIBLE]	[ILLEGIBLE]
Federal Tax identification Number or Social Security Number		State Purchasing:	Date

Doc # 98-001 amd Rev.5/18/98
hmo/molina am6 (8/7/02)

UTAH DEPARTMENT OF HEALTH
288 North 1460 West, Salt Lake City. Utah 84116
CONTRACT AMENDMENT

H9920205-06	006146
Department Log Number	State Contract Number

1. CONTRACT NAME:
   The name of this Contract is HMO-AFC/MOLINA, the Contract number assigned by the State Division of Finance is 006146, the Department log number assigned by the Utah Department of Health is H9920205, and this Amendment is number 6.

2. CONTRACTING PARTIES:
   This Contract Amendment is between the Utah Department of Health (DEPARTMENT), and Molina Healthcare of Utah (CONTRACTOR or MHU).

3. PURPOSE OF CONTRACT AMENDMENT:
   Effective July 1, 2002 this contract amendment clarifies and adds some provisions; delineates the reduced benefit package for the Non-Traditional Medicaid population; changes the benefit package for the Traditional Medicaid group; outlines the co-payment and co-insurance requirements for both Traditional and Non-Traditional Medicaid populations; and sets forth the payment methodology.

4. CHANGES TO CONTRACT:
   A. Effective July 1, 2002, replace Attachment B, Special Provisions, with Attachment B dated July 1, 2002, as attached to this Amendment #6.

   B. Effective July 1, 2002, replace Attachment C, Covered Services, with Attachment C dated July 1, 2002, as attached to this Amendment #6.

   C. Effective July 1, 2002, replace Attachment E (Tables 1, 2, 3, and revenue and cost definitions for Table 2) with Attachment E dated July 1, 2002, as attached to this Amendment #6.

   D. Effective July 1, 2002, replace Attachment F, Rates and Rate-Related Terms with Attachment F-4 dated July 1, 2002, as attached to this Amendment #6.

   E. All other provisions of the Contract remain unchanged.

5. If the Contractor is not a local public procurement unit as defined by the Utah Procurement Code (UCA Section 63-56-5), this Contract Amendment must be signed by a representative of the State Division of Finance and the State Division of Purchasing to bind the State and the Department to this Contract Amendment.

6. This Contract, its attachments, and all documents incorporated by reference constitute the entire agreement between the parties and supercede all prior negotiations, representations, or agreements, either written or oral between the parties relating to the subject matter of this Contract.

IN WITNESS WHEREOF, the parties sign this Contract Amendment.

CONTRACTOR: Molina Healthcare of Utah   UTAH DEPARTMENT OF HEALTH

CONTRACTOR		UTAH DEPARTMENT OF HEALTH	
By: /s/ G. K. Olsen		By: /s/	10/10/02
Signature of Authorized Individual	Date	Shari A. Watkins, C.P.A. Director Office of Fiscal Operations	Date
Print Name: Kirk Olsen			
		State Finance:	Date
Title: Chief Executive Officer			
33-0617992		/s/ [ILLEGIBLE]	10/17/02
Federal Tax identification Number or Social Security Number		State Purchasing:	Date

Doc # 98-001 amd Rev 5/18/98
hmo/molina am6 (9/05/02)

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For the purpose of the Contract all article, section, and subsection headings in these Attachments B, C, and D are for convenience in referencing the provisions of the Contract. They are not enforceable as part of the text of the Contract and may not be used to interpret the meaning of the provisions that lie beneath them.

ATTACHMENT B - SPECIAL PROVISIONS
Effective July 1, 2002

ARTICLE I - DEFINITIONS

For the purpose of the Contract:

A. "ADVANCE DIRECTIVES" means oral and written instructions about an individual's medical care, in the event the individual is unable to communicate. There are two types of Advance Directives: a living will and a medical power of attorney.

B. "BALANCE BILL" means the practice of billing patients for charges that exceed the amount that the MCO will pay.

C. "CHEC ELIGIBLE" means any Medicaid recipient under the age of 21 who is eligible to receive Early Periodic Screening Diagnostic and Treatment (EPSDT) services in accordance with 42 CFR Part 441, Subpart B.

D. "CHEC PROGRAM" or Child Health Evaluation and Care program is Utah's version of the federally mandated Early Periodic Screening, Diagnosis and Treatment (EPSDT) program as defined in 42 CFR Part 441, Subpart B. Medicaid recipients who are eligible for the Non-Traditional Medicaid Plan are not eligible to receive EPSDT services. (See Attachment C, Covered Services, U.)

E. "CHILD WITH SPECIAL HEALTH CARE NEEDS" means a child under 21 who has or is at increased risk for chronic physical, developmental, behavioral, or emotional conditions and requires health and related services of a type or amount beyond that required by children generally, including a child who, consistent with 1932(a)(2)(A) of the Social Security Act, 42 U.S.C., Section 1396u- 2(a)(2)(A):
(1) is blind or disabled or in a related population (eligible for SSI under title XVI of the Social Security Act);
(2) is in foster care or other out-of-home placement;
(3) is receiving foster care or adoption assistance; or
(4) is receiving services through a family-centered, community-based coordinated care system that receives grant funds described in section 501(a)(l)(D) of title V.

F. "DIVISION OF HEALTH CARE FINANCING" or "DHCF" means the division within the Department of Health responsible for the administration of the Utah Medicaid program.

G. "EMERGENCY SERVICES" means those services provided in a hospital, clinic, office, or other facility that is equipped to furnish the required care, after the sudden onset of 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 that the absence of immediate medical attention to result in:

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of a woman or her unborn child) in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

H. "ENROLLEE" means any Medicaid eligible: (1) who, at the time of enrollment resides within the geographical limits of the CONTRACTOR's Service Area; (2) whose name appears on the DEPARTMENT's Eligibility Transmission as a new, reinstate, or retroactive Enrollee; and (3) who is accepted for enrollment by the CONTRACTOR according to the conditions set forth in this Contract excluding residents of the Utah State Hospital, Utah State Developmental Center, and long-term care facilities except as defined in Attachment C.

I. "ENROLLEES WITH SPECIAL HEALTH CARE NEEDS" means enrollees who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount beyond that required by adults and children generally.

J. "ENROLLMENT AREA" or "Service Area" means the counties enumerated in Article II.

K. "FAMILY MEMBER" means all Medicaid eligibles who are members of the same family living at home.

L. "HOME AND COMMUNITY-BASED SERVICES" means services, not otherwise furnished under the State's Medicaid plan, that are furnished under a waiver of statutory requirements granted under the provisions of CFR Part 441, subpart G. These services cover an array of Home and Community-Based Services that are cost-effective and necessary for an individual to avoid institutionalization.

M. "MANAGED CARE ORGANIZATION" or "MCO" means an organization that meets the State Plan's definition of an HMO or prepaid health plan and which provides, either directly or through arrangement with other providers, comprehensive general medical services to Medicaid eligibles on a contractual prepayment basis.

N. "MARKETING MATERIAL" means materials in all mediums, including member handbooks, brochures and leaflets, newspaper, magazine, radio, television, billboard and yellow pages advertisements, and presentation materials used by marketing representatives. It includes materials mailed to, distributed to, or aimed at Medicaid clients specifically, and any material that mentions "Medicaid," "Medicaid Assistance," or "Title XIX."

O. "MEDICALLY NECESSARY" means any medical service that (a) is reasonably calculated to prevent, diagnose, or cure conditions in the Enrollee that endanger life, cause suffering or pain, cause deformity or malfunction, or threaten to cause a handicap, and (b) there is no equally effective course of treatment available or suitable for the Enrollee requesting the service which is more conservative or substantially less costly. Medical services will be of a quality that meets professionally recognized standards of health care, and will be substantiated by records including evidence of such medical necessity and quality. Those records will be made available to the DEPARTMENT upon request. FOR CHEC ENROLLEES, "Medically Necessary" means preventive screening services and other medical care, diagnostic services, treatment, and other measures necessary to correct or ameliorate defects and physical and mental illnesses and conditions, even

if the services are not included in the Utah State Medicaid Plan.

P. "MEMBER SERVICES" means a method of assisting Enrollees in understanding CONTRACTOR policies and procedures, facilitating referrals to participating specialists, and assisting in the resolution of problems and member complaints. The purpose of Member Services is to improve access to services and promote Enrollee satisfaction.

Q. "NON-TRADITIONAL MEDICAID PLAN" means the reduced benefit plan provided to Medicaid eligibles age 19 through 64 who are in certain TANF, Medically Needy, and Transitional Medicaid aid categories. Services covered under the reduced benefit plan are similar to the Traditional Medicaid Plan with some limitations and exclusions.

R. "PHYSICIAN INCENTIVE PLAN" means any compensation between a contracting organization and a physician group that may directly or indirectly have the effect of reducing or limiting services provided with respect to Enrollees in the organization.

S. "PREPAID MENTAL HEALTH PLAN" means the mental health centers that contract with the DEPARTMENT to provide inpatient and outpatient mental health services to Medicaid clients living within each mental health center's jurisdiction.

T. "PRIMARY CARE PROVIDER" or "PCP" means a health care provider the majority of whose practice is devoted to internal medicine, family/general practice or pediatrics. The MCO may allow other specialists to be PCPs, when appropriate. PCPs are responsible for delivering primary care services, coordinating and managing Enrollees' overall health and, authorizing referrals for other necessary care.

U. "RESTRICTION PROGRAM" means the Federally mandated program (42 CFR 431.54(e)) for Medicaid clients who over-utilize Medicaid services. If the DEPARTMENT in conjunction with the CONTRACTOR finds that an Enrollee has utilized Medicaid services at a frequency or amount that is not Medically Necessary, as determined in accordance with utilization guidelines adopted by the DEPARTMENT, the DEPARTMENT may place the Enrollee under the Restriction Program for a reasonable period of time to obtain Medicaid services from designated providers only.

V. "STATE PLAN" means the State Plan for organization and operation of the Medicaid program as defined pursuant to Section 1102 of the Social Security Act (42 U.S.C. 1302).

W. "TRADITIONAL MEDICAID PLAN" means the scope of services contained in the state plan provided to Medicaid eligibles who fall under one of the following eligibility groups:

(1) Section 1931 children and related poverty level populations (TANF/AFDC);
(2) Section 1931 pregnant women (TANF/AFDC);
(3) Blind/disabled children and related populations (SSI);
(4) Blind/disabled adults and related populations (SSI);
(5) Aged and related populations (SSI, QMB and Medicaid, Medicare and Medicaid);
(6) Foster care children;
(7) Individuals who qualify for Medicaid by paying a spenddown and are under age 19 or are also aged or disabled;
(8) Pregnant women (non-TANF/AFDC)

ARTICLE II - SERVICE AREA

The Service Area is limited to the counties of Cache, Davis, Iron, Salt Lake, Utah, Washington, and Weber.

ARTICLE III - ENROLLMENT, ORIENTATION, MARKETING, AND DISENROLLMENT

A. ENROLLMENT PROCESS

1. ENROLLEE CHOICE

The DEPARTMENT will offer potential Enrollees a choice among all MCOs available in the Enrollment Area. The DEPARTMENT will inform potential Enrollees of Medicaid benefits. The Medicaid client's intent to enroll is established when the applicant selects The CONTRACTOR, either verbally or by signing a choice of health care delivery form or equivalent. This initiates the action to send an advance notification to the CONTRACTOR. Medicaid Enrollees made eligible for a retroactive period prior to the current month are not eligible for CONTRACTOR enrollment during the retroactive period.

2. PERIOD OF ENROLLMENT

Each Enrollee will be enrolled for the period of the Contract or the period of Medicaid eligibility or until such person disenrolls or is disenrolled, whichever is earlier. Until the DEPARTMENT notifies the CONTRACTOR that an Enrollee is no longer Medicaid eligible, the CONTRACTOR may assume that the Enrollee continues to be eligible. Each Enrollee will be automatically re-enrolled at the end of each month unless that Enrollee notifies the DEPARTMENT's Health Program Representative of an intent not to re-enroll in the MCO prior to the benefit issuance date.

3. OPEN ENROLLMENT

The CONTRACTOR will have a continuous open enrollment period that meets the requirements of Section 1301(d) of the Public Health Service Act. The DEPARTMENT will certify, and the CONTRACTOR agrees to accept individuals who are eligible to be enrolled in the MCO under the provisions of this Contract:

a. in the order in which they apply; and
b. without restrictions unless authorized by the DEPARTMENT.

4. NO HEALTH SCREENING

The DEPARTMENT and the CONTRACTOR agree that no potential Enrollee will be pre-screened or selected by either party for enrollment on the basis of pre-existing health problems or on the basis of race, color, national origin, disability or age.

5. INDEPENDENT ENROLLMENT

Each Medicaid eligible can be enrolled or disenrolled in the MCO, independent of any other Family Member's enrollment or disenrollment.

6. REPRESENTATIVE POPULATION

The CONTRACTOR will service a population representative of the categories of eligibility within the area it serves.

7. ELIGIBILITY TRANSMISSION

a. IN GENERAL

Before the close of business of each day, the DEPARTMENT will provide to the CONTRACTOR an Eligibility Transmission which is an electronic file that includes individuals which the DEPARTMENT certifies as Medicaid eligible and who enrolled in the MCO. Eligibility transmissions include new Enrollees, reinstated Enrollees, retroactive Enrollees, deleted Enrollees and Enrollees whose eligibility information results in a change to a critical field. The Eligibility Transmission will be in accordance with the Utah Health Information Network (UHIN) standard. The DEPARTMENT represents and warrants to the CONTRACTOR that the appearance of an individual's name on the Eligibility Transmission, other than a deleted Enrollee, will be conclusive evidence for purposes of this Contract, that such person is enrolled in the program and qualifies for medical assistance under Medicaid Title XIX.

b. NEW ENROLLEES

New Enrollees are enrolled in this MCO until otherwise specified; these Enrollees will not appear on future transmissions unless there is a change in a critical field. Critical fields are coverage dates, recipient name, date of birth, date of death, sex, social security number, case information, address, telephone number, payment code, coordination of benefits, and the Enrollee's provider under the Restriction Program. Enrollees with a spenddown requirement will appear on the eligibility transmission on a month by month basis after the spenddown is met.

c. RETROACTIVE ENROLLEES

Retroactive Enrollees are those who were Enrollees previous to the current month. Retroactive Enrollees include newborn Enrollees or Enrollees who have been reported in one payment category in a previous month but have been changed to a new payment category for that previous month.

d. REINSTATED ENROLLEES

Reinstated Enrollees are those who were enrolled for the previous month and also closed at the end of the previous month. These Enrollees are eligible

retroactively to the beginning of the current month.

e. DELETED ENROLLEES

Deleted Enrollees are those who are no longer eligible for Medicaid or who were disenrolled from the MCO.

f. ADVANCED NOTIFICATION TRANSMISSION

An Advanced Notification Transmission is another electronic file (separate from the Eligibility Transmission) that will be sent to the CONTRACTOR when an individual has selected the MCO prior to becoming eligible for Medicaid. These individuals may or may not become eligible for Medicaid. Use of information about such individuals is restricted to providing the individual with an orientation to the MCO prior to the individual's eligibility for Medicaid. The CONTRACTOR is not required to orient individuals until they appear on the Eligibility Transmission.

8. CHANGE OF ENROLLMENT PROCEDURES

The CONTRACTOR will be advised of anticipated changes in DEPARTMENT policies and procedures as they relate to the enrollment process and their comments will be solicited. The CONTRACTOR agrees to be bound by such changes in DEPARTMENT policies and procedures that are mutually agreed upon by the CONTRACTOR and the DEPARTMENT.

B. MEMBER ORIENTATION

1. INITIAL CONTACT - GENERAL ORIENTATION

The CONTRACTOR will make a good faith effort to ensure that each Enrollee or Enrollee's family or guardian receives the CONTRACTOR's member handbook. The CONTRACTOR representative will make a good faith effort, as evidenced in written or electronic records, to make an initial contact with the Enrollee within 10 working days after the CONTRACTOR has been notified through the Eligibility Transmission of the Enrollee's MCO enrollment. The initial contact will be in person or by telephone (or in writing, but only if reasonable attempts have been made to make the contact in person by telephone) and will inform the Enrollee of the MCO rules and policies. The CONTRACTOR must ensure that Enrollees are provided interpreters, Telecommunication Device for the Deaf (TDD), and other auxiliary aids to ensure that Enrollees understand their rights and responsibilities. During the initial contact the CONTRACTOR Representative will provide, at a minimum, the following information to the Enrollee or potential Enrollee appropriate to the Enrollee's eligibility (Traditional versus Non-Traditional Medicaid):

a. specific written and oral instructions on the use of the CONTRACTOR's Covered Services and procedures;
b. availability and accessibility of all Covered Services, including the availability of family planning services and that the Enrollee may obtain family planning

services from Medicaid providers other than providers affiliated with the CONTRACTOR;

c. the client's rights and responsibilities as an Enrollee of the MCO, including the right to file a grievance and how to file a grievance;
d. the right to terminate enrollment with the MCO; and
e. encouragement to make a medical appointment with a provider.

2. IDENTIFICATION OF ENROLLEES WITH SPECIAL HEALTH CARE NEEDS

During the initial contact with each Enrollee, the CONTRACTOR representative will use a process that will identify children and adults with special health care needs. The CONTRACTOR representative will clearly describe to each Enrollee during the initial contact the process for requesting specialist care. When an Enrollee is identified as having special health care needs, the CONTRACTOR Representative will forward this information to a CONTRACTOR individual with knowledge of coordination of care and services necessary for such Enrollees. The CONTRACTOR individual with knowledge of coordination of care for Enrollees with special health care needs will make a good faith effort to contact Enrollees within ten working days after identification to begin coordination of health care needs, if necessary. The CONTRACTOR will not discriminate on the basis of health status or the need for health care services.

The DEPARTMENT's Health Program Representatives are responsible to forward information, i.e., pink sheets identifying Enrollees with special health care needs and limited language proficiency needs to the CONTRACTOR in a timely way coinciding with the daily Eligibility Transmission as much as possible.

3. INABILITY TO CONTACT ENROLLEE FOR ORIENTATION

If the CONTRACTOR's representative cannot contact the Enrollee within 10 working days or at all, the CONTRACTOR representative will document its efforts to contact the Enrollee.

4. ENROLLEES RECEIVING OUT-OF-PLAN CARE PRIOR TO ORIENTATION

If the Enrollee receives Covered Services by an out-of-plan provider after the first day of the month in which the client's enrollment became effective, and if a CONTRACTOR orientation either in-person or by telephone (or in writing, but only if reasonable attempts have been made to make the contact in person or by telephone) has not taken place prior to receiving such services, the CONTRACTOR is responsible for payment of the services rendered provided the DEPARTMENT informs the CONTRACTOR by the 20th of any month prior to the month that MCO enrollment begins.

C. MARKETING AND MEMBER EDUCATION

1. APPROVAL OF MARKETING MATERIALS

The CONTRACTOR's marketing plans, procedures and materials will be accurate, and may not mislead, confuse, or defraud either Enrollees or the DEPARTMENT. All Medicaid marketing plans, procedures and materials will be reviewed and approved by

the DEPARTMENT in consultation with the Medical Care Advisory Committee for Marketing Review before implemented or released by the CONTRACTOR. The DEPARTMENT will notify the CONTRACTOR of its approval or disapproval, in writing, of such materials within ten working days after receiving them unless the DEPARTMENT and the CONTRACTOR agree to another time frame. If the DEPARTMENT does not respond within the agreed upon time frame, the CONTRACTOR shall deem such materials approved. Marketing materials will not be approved if the DEPARTMENT determines that the material is materially inaccurate or misleading or otherwise makes material misrepresentations. Health education materials and newsletters not specifically related to Enrollees do not need to be approved by the DEPARTMENT.

a. NO DOOR-TO-DOOR, TELEPHONIC, OR "COLD CALL" MARKETING

The CONTRACTOR cannot, either directly or indirectly, conduct door-to-door, telephonic or "cold call" marketing of enrollment. These three marketing practices are prohibited whether conducted by the CONTRACTOR itself ("directly") or by an agent or independent contractor ("indirectly"). Cold call marketing is any unsolicited personal contact with a potential Enrollee by an employee or agent of a managed care entity for the purpose of influencing the individual to enroll with the CONTRACTOR's health plan. The CONTRACTOR may not entice a potential Enrollee to join its health plan by offering the sale of any other type of insurance as a bonus for enrollment. All other non-requested marketing approaches to Medicaid clients by the CONTRACTOR are also prohibited unless specifically approved in advance by the DEPARTMENT.

b. DISTRIBUTION OF MARKETING MATERIALS

Marketing materials must be distributed to the entire Service Area.

2. ENROLLEE MATERIALS MUST BE COMPREHENSIBLE

The CONTRACTOR will attempt to write all Enrollee and potential Enrollee information, instructional and educational materials, including member handbooks, at no greater than a sixth grade reading level. If the MCO has more than 5% of its Enrollees who speak a language other than English as a first language, the CONTRACTOR must make available written material (e.g. member handbooks, educational newsletters) in that language. Marketing materials must include a statement that the CONTRACTOR does not discriminate against any Enrollee on the basis of race, color, national origin, disability, or age in admission, treatment, or participation in its programs, services and activities. In addition, the materials must include the phone number of the nondiscrimination coordinator for Enrollees to call if they have questions about the nondiscrimination policy or desire to file a complaint or grievance alleging violations of the nondiscrimination policy.

3. MEMBER HANDBOOK

The CONTRACTOR will produce a member handbook that must be submitted to the

DEPARTMENT for review and approval before distribution. The DEPARTMENT will notify the CONTRACTOR in writing of its approval or disapproval within ten working days after receiving the member handbook unless the DEPARTMENT and CONTRACTOR agree to another time frame. If the DEPARTMENT does not respond within the agreed upon time frame, the CONTRACTOR may deem such materials are approved. If there are changes to the content of the material in the handbook, the CONTRACTOR must update the member handbook and submit a draft to the DEPARTMENT for review and approval before distribution to its Enrollees. At a minimum, the member handbook must explain in clear terms the following information:

a. The scope of benefits provided by the CONTRACTOR delineating Traditional versus Non-Traditional Medicaid scopes of service;
b. Instructions on where and how to obtain Covered Services, including referral requirements;
c. Instructions on what to do in an emergency or urgent medical situation, including emergency numbers;
d. Enrollee options on obtaining family planning services;
e. Instructions on how to choose a PCP and how to change PCPs;
f. Description on Enrollee cost-sharing requirements (if applicable);
g. Toll-free telephone number;
h. Description of Member Services function;
i. How to register a complaint or grievance;
j. Information on Advance Directives;
k. Services covered by Medicaid, but not covered by the CONTRACTOR;
1. Clients' rights and responsibilities;
m. A statement that the CONTRACTOR does not discriminate against any Enrollee on the basis of race, color, national origin, disability, or age in admission, treatment, or participation in its programs, services and activities; and
n. The phone number of the nondiscrimination coordinator for Enrollees to call if they have questions about the nondiscrimination policy or desire to file a complaint or grievance alleging violations of the nondiscrimination policy.

4. NOTIFICATION TO ENROLLEES OF POLICIES AND PROCEDURES

a. CHANGES TO POLICIES AND PROCEDURES

The CONTRACTOR must periodically notify Enrollees, in writing, of changes to its plan such as changes to its policies or procedures either through a newsletter or other means.

b. ANNUAL EDUCATION ON EMERGENCY CARE AND GRIEVANCE PROCEDURES

The CONTRACTOR must annually reinforce, in writing, to Enrollees how to access emergency and urgent services and how to register a complaint or grievance.

5. MONTHLY NOTIFICATION TO DEPARTMENT OF CHANGES IN PROVIDER NETWORK

The CONTRACTOR must notify the DEPARTMENT at least monthly of changes in its

provider network so that the DEPARTMENT can ensure its listing of providers is accurate.

D. DISENROLLMENT BY ENROLLEE

1. ENROLLEE's RIGHT TO DISENROLL

Enrollees will have the right to disenroll from this MCO at any time with or without cause. The disenrollment will be effective once the DEPARTMENT has been notified by the Enrollee and the DEPARTMENT issues a new Medicaid card and the disenrollment is indicated on the Eligibility Transmission.

2. ENROLLEES IN AN INPATIENT HOSPITAL SETTING

The DEPARTMENT agrees that if a new Enrollee is a patient in an inpatient hospital setting on the date the new Enrollee's name appears on the CONTRACTOR Eligibility Transmission, the obligation of the CONTRACTOR to provide Covered Services to such person will commence following discharge. If an Enrollee is a patient in an inpatient hospital setting on the date that his or her name appears as a deleted Enrollee on the CONTRACTOR Eligibility Transmission or he or she is otherwise disenrolled under this Contract, the CONTRACTOR will remain financially responsible for such care until discharge.

3. ANNUAL STUDY OF ENROLLEES WHO DISENROLLED

Annually, the DEPARTMENT and CONTRACTOR will work cooperatively to conduct an analysis of Enrollees who have voluntarily disenrolled from this MCO. The results of the analysis will include explanations of patterns of disenrollments and strategies or a corrective action plan to address unusual rates or patterns of disenrollment. The DEPARTMENT will inform the CONTRACTOR of such disenrollments.

E. DISENROLLMENT BY CONTRACTOR

1. CANNOT DISENROLL FOR ADVERSE CHANGE IN ENROLLEE's HEALTH

The CONTRACTOR may not terminate enrollment because of an adverse change in the Enrollee's health.

2. VALID REASONS FOR DISENROLLMENT

The CONTRACTOR may initiate disenrollment of any Enrollee's participation in the MCO upon one or more of the following grounds:

a. For reasons specifically identified in the CONTRACTOR's member handbook.
b. When the Enrollee ceases to be eligible for medical assistance under the State Plan, in accordance with Title 42 USCA, 1396, et. seq., and as finally determined by the DEPARTMENT.
c. Upon termination or expiration of the Contract.
d. Death of the Enrollee.

e. Confinement of the Enrollee in an institution when confinement is not a Covered Service under this Contract.

f. Violation of enrollment requirements developed by the CONTRACTOR and approved by the DEPARTMENT but only after the CONTRACTOR and/or the Enrollee has exhausted the CONTRACTOR's applicable internal grievance procedure.

3. APPROVAL BY DEPARTMENT REQUIRED

To initiate disenrollment of an Enrollee's participation with this MCO, the CONTRACTOR will provide the DEPARTMENT with documentation justifying the proposed disenrollment. The DEPARTMENT will approve or deny the disenrollment request in writing within thirty (30) days of receipt of the request. Failure by the DEPARTMENT to deny a disenrollment request within such thirty (30) day period will constitute approval of such disenrollment requests.

4. ENROLLEE's RIGHT TO FILE A GRIEVANCE

If the DEPARTMENT approves the CONTRACTOR's disenrollment request, the CONTRACTOR will give the Enrollee thirty (30) days written notice of the proposed disenrollment, and will notify the Enrollee of his or her opportunity to invoke the internal grievance procedure and appeals process for a fair hearing. The CONTRACTOR will give a copy of the written notice to the DEPARTMENT at the time the notice is sent to the Enrollee.

5. REFUSAL OF RE-ENROLLMENT

If a person is disenrolled because of violation of responsibilities included in the CONTRACTOR's member handbook, the CONTRACTOR may refuse re-enrollment of that Enrollee.

F. ENROLLEE TRANSITION BETWEEN MCOs

1. MUST ACCEPT PRE-ENROLLMENT PRIOR AUTHORIZATIONS

For Covered Services other than inpatient, home health services, and medical equipment, if authorization has been given for a Covered Service and an enrollee transitions between MCOs prior to the delivery of such Covered Service, the receiving MCO shall be bound by the relinquishing MCO's prior authorization until the receiving MCO has evaluated the medical necessity of the service and agrees with the relinquishing MCO's prior authorization or has made a different determination. (See Article IV, Benefits, Section F, Clarification of Payment Responsibilities, Subsection 5, for inpatient, home health services, and medical equipment explanations.)

2. MUST PROVIDE MEDICAL RECORDS TO ENROLLEE's NEW MCO

When enrollees are transitioned between MCOs the relinquishing MCO's provider will submit, upon request of the new MCO's provider, any critical medical information about the transitioning enrollee prior to the transition including, but not limited to, whether the

member is hospitalized, pregnant, involved in the process of organ transplantation, scheduled for surgery or post-surgical follow-up on a date subsequent to transition, scheduled for prior-authorized procedures or therapies on a date subsequent to transition, receiving dialysis or is chronically ill (e.g. diabetic, hemophilic, HIV positive).

G. ENROLLEE TRANSITION FROM FEE-FOR-SERVICE TO MCO OR FROM MCO TO FEE-FOR-SERVICE

1. CONTRACTOR MUST ACCEPT PRE-ENROLLMENT PRIOR AUTHORIZATIONS

For Covered Services other than inpatient, home health services, and medical equipment, if authorization has been given for a Covered Service and a Medicaid client transitions from Medicaid fee-for-service to enrollment with the CONTRACTOR's health plan prior to the delivery of such Covered Service, the CONTRACTOR shall be bound by the DEPARTMENT's fee-for-service prior authorization until the CONTRACTOR has evaluated the medical necessity of the service and agrees with the DEPARTMENT's fee-for-service prior authorization or has made a different determination. (See Article IV, Benefits, Section F, Clarification of Payment Responsibilities, Subsection 5, for inpatient, home health services, and medical equipment explanations.)

2. DEPARTMENT MUST ACCEPT CONTRACTOR's PRIOR AUTHORIZATION

For Covered Services other than inpatient, home health services, and medical equipment, if authorization has been given for a Covered Service and an Enrollee transitions to Medicaid fee-for-service prior to the delivery of such Covered Service, the DEPARTMENT shall be bound by the CONTRACTOR's prior authorization until the DEPARTMENT has evaluated the medical necessity of the service and agrees with the CONTRACTOR's fee-for-service prior authorization or has made a different determination. (See Article IV, Benefits, Section F, Clarification of Payment Responsibilities, Subsection 5, for inpatient, home health services, and medical equipment explanations.)

3. MUST PROVIDE MEDICAL RECORDS TO ENROLLEE's MCO OR TO THE DEPARTMENT

When enrollees are transitioned from MCO to fee-for-service or from fee-for-service to MCO, the relinquishing entity (MCO or DEPARTMENT) will submit, upon request of the new entity, any critical medical information about the transitioning Medicaid client prior to the transition including, but not limited to, whether the member is hospitalized, pregnant, involved in the process of organ transplantation, scheduled for surgery or post-surgical follow-up on a date subsequent to transition, scheduled for prior-authorized procedures or therapies on a date subsequent to transition, receiving dialysis or is chronically ill (e.g. diabetic, hemophilic, HIV positive).

ARTICLE IV - BENEFITS

A. IN GENERAL

The CONTRACTOR will provide to Enrollees under this Contract, directly or through arrangements with subcontractors, all Medically Necessary Covered Services described in

Attachment C as promptly and continuously as is consistent with generally accepted standards of medical practice. The subcontractors will follow generally accepted standards of medical care in diagnosing Enrollees who request services from the CONTRACTOR.

B. PROVIDER SERVICES FUNCTION

The CONTRACTOR must operate a Provider Services function during regular business hours. At a minimum, Provider Services staff must be responsible for the following:

1. Training, including ongoing training, of the CONTRACTOR's providers on Medicaid rules and regulations that will enable providers to appropriately render services to Enrollees;
2. Assisting providers to verify whether an individual is enrolled with the MCO;
3. Assisting providers with prior authorization and referral protocols;
4. Assisting providers with claims payment procedures;
5. Fielding and responding to provider questions and complaints and grievances.

C. SCOPE OF SERVICES

1. RESPONSIBLE FOR ALL BENEFITS IN ATTACHMENT C (COVERED SERVICES)

Except as otherwise provided for cases of Emergency Services, the CONTRACTOR has the exclusive right and responsibility to arrange for all benefits listed in Attachment C. The CONTRACTOR is responsible for payment of Emergency Services 24 hours a day and 7 days a week whether the service was provided by a network or out-of-network provider and whether the service was provided in or out of the CONTRACTOR's Service Area.

2. CHANGES TO BENEFITS

Amendments, revisions, or additions to the State Plan or to State or Federal regulations, guidelines, or policies and court or administrative orders will, insofar as they affect the scope or nature of benefits available to Enrollees, be amendments to the Covered Services under Attachment C. The DEPARTMENT will notify the CONTRACTOR, in writing, of any such changes and their effective date. Rate adjustments, when appropriate, will be negotiated between the DEPARTMENT and the CONTRACTOR.

3. MEDICAL NECESSITY DENIALS

When the CONTRACTOR determines that a service will not be covered due to the lack of medical necessity, the CONTRACTOR must send all documentation supporting their decision to the DEPARTMENT for its review before the CONTRACTOR's determination is deemed final, when the following conditions are met:

a. there are no established national standards for determining medical necessity and
b. the DEPARTMENT does not have medical necessity criteria for the service.

The DEPARTMENT will review the documentation and determine what the

DEPARTMENT's decision would be regarding coverage for the service. The DEPARTMENT and the CONTRACTOR will work collaboratively in making a final decision on whether the service is to be covered by the CONTRACTOR.

D. SUBCONTRACTS

1. NO DISCRIMINATION BASED ON LICENSE OR CERTIFICATION

The CONTRACTOR shall not discriminate against providers with respect to participation, reimbursement, or indemnification as to any provider who is 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.

2. ANY COVERED SERVICE MAY BE SUBCONTRACTED.

Any Covered Service may be subcontracted. All subcontracts will be in writing and will include the general requirements of this Contract that are appropriate to the service or activity including confidentiality requirements and will assure that all duties of the CONTRACTOR under this Contract are performed. No subcontract terminates the legal responsibility of the CONTRACTOR to the DEPARTMENT to assure that all activities under this Contract are carried out. The CONTRACTOR will make all subcontracts available upon request.

3. NO PROVISIONS TO REDUCE OR LIMIT MEDICALLY NECESSARY SERVICES

The CONTRACTOR will ensure that subcontractors abide by the requirements of Section 1128(b) of the Social Security Act prohibiting the CONTRACTOR and other such providers from making payments directly or indirectly to a physician or other provider as an inducement to reduce or limit Medically Necessary services provided to Enrollees.

4. REQUIREMENT OF 60 DAYS WRITTEN NOTICE PRIOR TO TERMINATION OF CONTRACT

All subcontracts and agreements will include a provision stating that if either party (the subcontractor or CONTRACTOR) wishes to terminate the subcontract or agreement, whichever party initiates the termination will give the other party written notice of termination at least 60 calendar days prior to the effective termination date. The CONTRACTOR will notify the DEPARTMENT of the termination on the same day that the CONTRACTOR either initiates termination or receives the notice of termination from the subcontractor.

5. COMPLIANCE WITH CONTRACTOR's QUALITY ASSURANCE PLAN

All of the CONTRACTOR's providers must be aware of the CONTRACTOR's Quality Assurance Plan and activities. All subcontracts with the CONTRACTOR must include a requirement securing cooperation with the CONTRACTOR's Quality Assurance Plan and activities and must allow the CONTRACTOR access to the subcontractor's medical records of its Enrollees.

6. UNIQUE IDENTIFIER REQUIRED

All physicians who provide services under this Contract must have a unique identifier in accordance with the system established under section 1173(b) of the Social Security Act and in accordance with the Health Insurance Portability and Accountability Act.

7. PAYMENT OF PROVIDER CLAIMS

The CONTRACTOR must pay its providers on a timely basis consistent with the claims payment procedures described in section 1902(a)(37)(A) of the Social Security Act and the implementing Federal regulation at 42 CFR 447.45, unless the provider and CONTRACTOR agree to an alternate payment schedule. The Contractor must ensure that 90 percent of claims for payment (for which no further written information or substantiation is required in order to make payment) made for Covered Services and furnished by its providers are paid within 30 days of receipt of such claims and that 99 percent of such claims are paid within 90 days of the date of receipt of such claims.

8. FEDERALLY QUALIFIED HEALTH CENTERS (FQHCs)

If the CONTRACTOR enters into a subcontract with a Federally Qualified Health Center (FQHC), the CONTRACTOR will reimburse the FQHC an amount not less than what the CONTRACTOR pays comparable providers that are not FQHCs.

E. CLARIFICATION OF COVERED SERVICES

1. EMERGENCY SERVICES

a. IN GENERAL

The CONTRACTOR must provide coverage for Emergency Services without regard to prior authorizations or the emergency care provider's contractual relationship with the CONTRACTOR. The CONTRACTOR must inform their Enrollees that access to Emergency Services is not restricted and that if an Enrollee experiences a medical emergency, he or she may obtain services from a non-plan physician or other qualified provider, without penalty. However, the CONTRACTOR may require the Enrollee to notify the CONTRACTOR within a specified time after the Enrollee's condition is stabilized, and may require the Enrollee to obtain prior authorization for any follow-up care delivered pursuant to the emergency. The CONTRACTOR must comply with Medicare guidelines for post-stabilization of care.

The CONTRACTOR must pay for services where the presenting symptoms are of sufficient severity that a person with average knowledge of health and medicine would reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of a woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

The CONTRACTOR may 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, turned out to be non-emergency in nature.

b. DETERMINING LIABILITY FOR EMERGENCY SERVICES

1) Presence of a clinical emergency

If the screening examination leads to a clinical determination by the examining physician that an actual emergency medical condition exists, the CONTRACTOR must pay for both the services involved in the screening examination and the services required to stabilize the Enrollee.

2) Emergency services continue until the Enrollee can be safely discharged or transferred

The CONTRACTOR must pay for all Emergency Services that 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 Enrollee's condition is likely to result from, or occur during, discharge of the Enrollee or transfer of the Enrollee to another facility. If there is a disagreement between a hospital and the CONTRACTOR concerning whether the Enrollee is stable enough for discharge or transfer, or whether the medical benefits of an unstabilized transfer outweigh the risks, the judgement of the attending physician(s) actually caring for the Enrollee at the treating facility prevails and is binding on the CONTRACTOR. The CONTRACTOR may establish arrangements with hospitals whereby the CONTRACTOR may send one of its own physicians with appropriate ER privileges to assume the attending physician's responsibilities to stabilize, treat, and transfer the Enrollee.

3) Absence of a clinical emergency

If the screening examination leads to a clinical determination by the examining physician that an actual emergency medical condition did not exist, then the determining factor for payment liability should be whether the Enrollee had acute symptoms of sufficient severity at the time of presentation. In these cases, the CONTRACTOR must review the presenting symptoms of the Enrollee and must pay for all services involved in the screening examination where the presenting symptoms (including severe pain) were of sufficient severity to have warranted emergency attention under the prudent layperson standard.

4) Referrals

When an Enrollee's Primary Care Physician or other plan representative instructs the Enrollee to seek emergency care in or out of network, the

CONTRACTOR is responsible for payment of the medical screening examination and for other Medically Necessary Emergency Services, without regard to whether the Enrollee meets the prudent layperson standard.

2. CARE PROVIDED IN SKILLED NURSING FACILITIES

a. IN GENERAL: STAYS LASTING 30 DAYS OR LESS

The CONTRACTOR may provide long term care for Enrollees in skilled nursing facilities and then reimburse such facilities when the plan of care includes a prognosis of recovery and discharge within 30 days. It is the responsibility of a CONTRACTOR physician to make the determination if the patient will require the services of a nursing facility for fewer or greater than 30 days.

b. PROCESS FOR STAYS LONGER THAN 30 DAYS

When the prognosis of an Enrollee indicates that long term care greater than 30 days will be required, the following process will occur:

1) The CONTRACTOR will notify the Enrollee, hospital discharge planner, and nursing facility that the CONTRACTOR will not be responsible for the services provided for the Enrollee during the stay at the skilled nursing facility.

2) The CONTRACTOR will notify the DHCF, Bureau of Managed Health Care (BMHC) of this determination and the BMHC will change the status of the Enrollee to fee-for-service.

c. PROCESS FOR STAYS LESS THAN 30 DAYS

When the prognosis of skilled nursing facility services is anticipated to be less than 30 days, but during the 30-day period the CONTRACTOR determines that the Enrollee will require skilled nursing facility services for greater than 30 days, the following process will be in effect:

1) The CONTRACTOR will notify the nursing facility that a determination has been made that the Enrollee will require services for more than 30 days.

2) The CONTRACTOR will notify the DHCF, Bureau of Managed Health Care, of the determination that the Enrollee will require services in a nursing facility for more than 30 days.

3) The CONTRACTOR will be responsible for payment for three working days after the CONTRACTOR has notified the nursing facility that skilled nursing care will be required for more than 30 days.

3. ENROLLEES WITH SPECIAL HEALTH CARE NEEDS

a. IN GENERAL

The CONTRACTOR will ensure there is access to all Medically Necessary Covered Services to meet the health needs of Enrollees with special health care needs. Individuals with special health care needs are those who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount beyond that required by adults and children generally.

b. IDENTIFICATION

The CONTRACTOR will identify Enrollees with special health care needs using a process at the initial contact made by the CONTRACTOR Representative to educate the client and will offer the client care coordination or case management services. Care coordination services are services to assist the client in obtaining Medically Necessary Covered Services from the CONTRACTOR or another entity if the medical service is not covered under the Contract.

c. CHOOSING A PRIMARY CARE PROVIDER

The CONTRACTOR will have a mechanism to inform care givers and, when appropriate, Enrollees with special health care needs about primary care providers who have training in caring for such Enrollees so that an informed selection of a provider can be made. The CONTRACTOR will have primary care providers with skills and experience to meet the needs of Enrollees with special health care needs. The CONTRACTOR will allow an appropriate specialist to be the primary care provider but only if the specialist has the skills to monitor the Enrollee's preventive and primary care services.

d. REFERRALS AND ACCESS TO SPECIALTY PROVIDERS

The CONTRACTOR will ensure there is access to appropriate specialty providers to provide Medically Necessary Covered Services for adults and children with special health care needs. If the CONTRACTOR does not employ or contract with a specialty provider to treat a special health care condition at the time the Enrollee needs such Covered Services, the CONTRACTOR will have a process to allow the Enrollee to receive Covered Services from a qualified specialist who may not be affiliated with the CONTRACTOR. The CONTRACTOR will reimburse the specialist for such care at no less than Medicaid's rate for the service when the service is rendered. The process for requesting specialist's care will be clearly described by the CONTRACTOR and explained to each Enrollee during the initial contact with the Enrollee.

If the CONTRACTOR restricts the number of referrals to specialists, the CONTRACTOR will not penalize those providers who make such referrals for Enrollees with special health care needs.

e. SURVEY OF ENROLLEES WITH SPECIAL HEALTH CARE NEEDS

At least every two years, the CONTRACTOR in conjunction with the DEPARTMENT will survey a sample of Enrollees with special health care needs using a national consumer assessment questionnaire, to evaluate their perceptions of services they have received. The survey process, including the survey instrument, will be standardized and developed collaboratively between the DEPARTMENT and all contracting MCOs. The DEPARTMENT will analyze the results of the surveys. The results and analysis of the surveys will be reviewed by the CONTRACTOR's quality assurance committee for action.

f. COLLABORATION WITH OTHER PROGRAMS

If the individual with special health care needs is enrolled in the Prepaid Mental Health Plan or is enrolled in any of the Medicaid home and community-based waiver programs and is receiving case management services through that program, or is covered by one of the other Medicaid targeted case management programs, the CONTRACTOR care coordinator will collaborate with the appropriate program person, i.e., the targeted case manager, etc., for that program once the program person has contacted the CONTRACTOR care coordinator. When necessary, the CONTRACTOR care coordinator will make an effort to contact the program person of those Enrollees who have medical needs that require such coordination.

The CONTRACTOR must coordinate health care needs for children with special health care needs with the services of other agencies (e.g., mental and substance abuse, public health departments, transportation, home and community based care, developmental disabilities, Title V, local schools, IDA programs, and child welfare), and with families, caregivers, and advocates.

g. REQUIRED ELEMENTS OF A CASE MANAGEMENT SYSTEM

A case management system includes but is not limited to:

1) procedures and the capacity to implement the provision of individual needs assessment including the screening for special needs (e.g. mental health, high risk health problems, functional problems, language or comprehension barriers); the development of an individual treatment plan as necessary based on the needs assessment; the establishment of treatment objectives, treatment follow-up, the monitoring of outcomes, and a process to ensure that treatment plans are revised as necessary. These procedures will be designed to accommodate the specific cultural and linguistic needs of the Enrollee;

2) procedures designed to address those Enrollees, including children with special health care needs, who may require services from multiple providers, facilities and agencies and require complex coordination of benefits and services, including social services and other community resources;

3) a strategy to ensure that all Enrollees and/or authorized Family Members or guardians are involved in treatment planning and consent to the medical treatment;

4) procedures and criteria for making referrals and coordinating care by specialists and sub-specialists that will promote continuity as well as cost-effectiveness of care; and

5) procedures to provide continuity of care for new Enrollees to prevent disruption in the provision of Covered Services that include, but are not limited to, appropriate case management staff able to evaluate and handle individual case transition and care planning, internal mechanisms to evaluate plan networks and special case needs.

h. HOSPICE

If an Enrollee is receiving hospice services at the time of enrollment in the MCO or if the Enrollee is already enrolled in the MCO and has less than six months to live, the Enrollee will be offered hospice services or the continuation of hospice services if he or she is already receiving such services prior to enrollment in the MCO.

4. INPATIENT HOSPITAL SERVICES

If a CONTRACTOR's provider admits an Enrollee for inpatient hospital care, the CONTRACTOR has the responsibility for all services needed by the Enrollee during the hospital stay that are ordered by the CONTRACTOR's provider. Needed services include but are not limited to diagnostic tests, pharmacy, and physician services, including services provided by psychiatrists. If diagnostic tests conducted during the inpatient stay reveal that the Enrollee's condition is outside the scope of the CONTRACTOR's responsibility, the CONTRACTOR remains responsible for the Enrollee until the Enrollee is discharged or until responsibility is transferred to another appropriate entity and the entity agrees to take financial responsibility, including negotiating a payment for services. If the Enrollee is discharged and needs further services, the admitting CONTRACTOR will coordinate with the other appropriate entity to ensure continued care is provided. The CONTRACTOR and appropriate entity will work cooperatively in the best interest of the Enrollee. The appropriate entity includes, but is not limited to, a Prepaid Mental Health Plan or another MCO.

5. MATERNITY STAYS

a. THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT (NMHPA)

The CONTRACTOR must meet the requirements of the Newborns' and Mothers' Health Protection Act (NMHPA). The CONTRACTOR must record early discharge information for monitoring, quality, and improvement purposes. The CONTRACTOR will ensure that coverage is provided with respect to a mother who is an Enrollee and her newborn child for a minimum of 48 hours of inpatient care following a normal vaginal delivery, and a minimum of 96 hours

of inpatient care following a caesarean section, without requiring the attending provider to obtain authorization from the CONTRACTOR in order to keep a mother and her newborn child in the inpatient setting for such period of time.

b. EARLY DISCHARGES

Notwithstanding the prior sentence, the CONTRACTOR will not be required to provide coverage for post-delivery inpatient care for a mother who is an Enrollee and her newborn child during such period of time if (1) a decision to discharge the mother and her newborn child prior to the expiration of such period is made by the attending provider in consultation with the mother; and (2) the CONTRACTOR provides coverage for timely post-delivery follow-up care.

c. POST-DELIVERY CARE

Post-delivery care will be provided to a mother and her newborn child by a registered nurse, physician, nurse practitioner, nurse midwife or physician assistant experienced in maternal and child health in (1) the home, a provider's office, a hospital, a federally qualified health center, a federally qualified rural health clinic, or a State health department maternity clinic; or (2) another setting determined appropriate under regulations promulgated by the Secretary of Health and Human Services, (including a birthing center or an intermediate care facility); except that such coverage will ensure that the mother has the option to be provided with such care in the home.

d. TIMELY POST-DELIVERY CARE

"Timely post-delivery care" means health care that is provided (1) following the discharge of a mother and her newborn child from the inpatient setting; and (2) in a manner that meets the health needs of the mother and her newborn child, that provides for the appropriate monitoring of the conditions of the mother and child, and that occurs within the 24 to 72 hour period immediately following discharge.

6. CHILDREN IN CUSTODY OF THE DEPARTMENT OF HUMAN SERVICES

a. IN GENERAL

The CONTRACTOR will work with the Division of Child and Family Services (DCFS) or the Division of Youth Corrections (DYC) in the Department of Human Services (DHS) to ensure systems are in place to meet the health needs of children in custody of the Department of Human Services. The CONTRACTOR will ensure these children receive timely access to appointments through coordination with DCFS or DYC. The CONTRACTOR must have available providers who have experience and training in abuse and neglect issues.

The CONTRACTOR or its providers will make every reasonable effort to ensure that a child who is in custody of the Department of Human Services may

continue to use the provider with whom the child has an established professional relationship when the provider is part of the CONTRACTOR's network. The CONTRACTOR will facilitate timely appointments with the provider of record to ensure continuity of care for the child.

While it is the CONTRACTOR's responsibility to ensure Enrollees who are children in the custody of DHS have access to needed services, DHS personnel are primarily responsible to assist children in custody in arranging for and getting to medical appointments and evaluations with the CONTRACTOR's network of providers. DHS staff are primarily responsible for contacting the CONTRACTOR to coordinate care for children in custody and informing the CONTRACTOR of the special health care needs of these Enrollees. The Fostering Healthy Children staff may assist the DHS staff in performing these functions by communicating with the CONTRACTOR.

b. SCHEDULE OF VISITS

1) Where physical and/or sexual abuse is suspected

In cases where the child protection worker suspects physical and/or sexual abuse, the CONTRACTOR will ensure that the child has access to an appropriate examination within 24 hours of notification that the child was removed from the home. If the CONTRACTOR cannot provide an appropriate examination, the CONTRACTOR will ensure the child has access to a provider who can provide an appropriate examination within the 24 hour period.

2) All other cases

In all other cases, the CONTRACTOR will ensure that the child has access to an initial health screening within five calendar days of notification that the child was removed from the home. The CONTRACTOR will ensure this exam identifies any health problems that might determine the selection of a suitable placement, or require immediate attention.

3) CHEC exams

In all cases, the CONTRACTOR will ensure that the child has access to a Child Health Evaluation and Care (CHEC) screening within 30 calendar days of notification that the child was removed from the home. Whenever possible, the CHEC screening should be completed within the five-day time frame. Additionally, the CONTRACTOR will ensure the child has access to a CHEC screening according to the CHEC periodicity schedule until age six, then annually thereafter.

7. ORGAN TRANSPLANTATIONS

a. IN GENERAL

All organ transplantation services are the responsibility of the CONTRACTOR for all Enrollees in accordance with the criteria set forth in Rule R414-10A of the Utah Administrative Code, unless amended under the provisions of Attachment B, Article IV (Benefits), Section C, Subsection 3 of this Contract. The DEPARTMENT's criteria will be provided to the CONTRACTOR.

b. SPECIFIC ORGAN TRANSPLANTATIONS COVERED

The following transplantations are covered for Enrollees under the Traditional Medicaid Plan as described in Rule R414-10A: Kidney, liver, cornea, bone marrow, stem cell, heart, intestine, lung, pancreas, small bowel, combination heart/lung, combination intestine/liver, combination kidney/pancreas, combination liver/kidney, multi visceral, and combination liver/small bowel. Transplantations for Enrollees under the Non-Traditional Medicaid Plan are limited to kidney, liver, cornea, bone marrow, stem cell, heart, and lung.

c. PSYCHOSOCIAL EVALUATION REQUIRED

Enrollees who have applied for organ transplantations, except cornea or kidney, must undergo a comprehensive psycho-social evaluation by a board-certified or board-eligible psychiatrist. The evaluation must include a comprehensive history regarding substance abuse and compliance with medical treatment. In addition, the parent(s) or guardian(s) of Enrollees who are less than 18 years of age must undergo a psycho-social evaluation that includes a comprehensive history regarding substance abuse, and past and present compliance with medical treatment.

If a request is made for a transplantation not listed above, the CONTRACTOR will contact the DEPARTMENT. Such requests will be addressed as set forth in R414-10A-23.

d. OUT-OF-STATE TRANSPLANTATIONS

When the CONTRACTOR arranges the transplantation to be performed out-of-state, the CONTRACTOR is responsible for coverage of food, lodging, transportation and airfare expenses for the Enrollee and attendant. The CONTRACTOR will follow, at a minimum, the DEPARTMENT's criteria for coverage of food, lodging, transportation and airfare expenses.

8. MENTAL HEALTH SERVICES

When an Enrollee presents with a possible mental health condition to his or her CONTRACTOR primary care physician, it is the responsibility of the primary care provider to determine whether the Enrollee should be referred to a psychologist, pediatric specialist, psychiatrist, neurologist, or other specialist. Mental health

conditions may be handled by the CONTRACTOR primary care provider and referred to the Enrollee's Prepaid Mental Health Plan when more specialized services are required for the Enrollee. CONTRACTOR primary care providers may seek consultation from the Prepaid Mental Health Plan when the primary care provider chooses to manage the Enrollee's symptoms.

An independent panel comprised of specialists appropriate to the concern will be established by the DEPARTMENT with representatives from the CONTRACTOR and Prepaid Mental Health Plan to adjudicate disputes regarding which entity (the CONTRACTOR or Prepaid Mental Health Plan) is responsible for payment and/or treatment of a condition. The panel will be convened on a case-by-case basis. The CONTRACTOR and Prepaid Mental Health Plan will adhere to the final decision of the panel.

9. DEVELOPMENTAL AND ORGANIC DISORDERS

a. COVERED SERVICES FOR CHILD ENROLLEES THROUGH AGE 20

1) The CONTRACTOR is responsible for all inpatient and physician outpatient Covered Services for child Enrollees with developmental (ICD-9 codes 299 through 299.8 and 317 through 319.9) or organic diagnoses (ICD-9 codes 290 through 294.9 and 310 through 310.9) including, but not limited to, diagnostic work-ups and other medical care such as medication management services related to the developmental or organic disorder.

2) The CONTRACTOR is responsible for all psychological evaluations and testing including neuropsychological evaluations and testing for child Enrollees with developmental or organic disorders such as brain tumors, brain injuries, and seizure disorders.

b. COVERED SERVICES FOR ADULT ENROLLEES AGE 21 AND OLDER

The CONTRACTOR is responsible for all inpatient and physician outpatient Covered Services for adult Enrollees with developmental (ICD-9 codes 299 through 299.8 and 317 through 319.9) and organic diagnoses (ICD-9 codes 290 through 294.9 and 310 through 310.9) including diagnostic work-ups and other medical care such as medication management services related to the developmental or organic disorder.

c. NON-COVERED SERVICES

1) Psychological evaluations and testing including neuropsychological evaluations and testing for adult Enrollees is not the responsibility of the CONTRACTOR.

2) Habilitative and behavioral management services are not the responsibility of the CONTRACTOR. If habilitative services are required, the Enrollee should be referred to the Division of Services for

People with Disabilities (DSPD), the school system, the Early Intervention Program, or similar support program or agency. The Enrollee should also be referred to DSPD for consideration of other benefits and programs that may be available through DSPD. Habilitative services are defined in Section 1915(c)(5)(a) of the Social Security Act as "services designed to assist individuals in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community based settings."

d. RESPONSIBILITY OF THE PREPAID MENTAL HEALTH PLAN

The Prepaid Mental Health Plan is responsible for the treatment of the mental illness to individuals with both an organic and a psychiatric diagnosis or with both a developmental and a psychiatric diagnosis.

10. OUT-OF-STATE ACCESSORY SERVICES

When the CONTRACTOR arranges a Covered Service to be performed out-of-state, the CONTRACTOR is responsible for coverage of airfare, food and lodging for the Enrollee and one attendant during the stay at the out-of-state facility. Ground transportation costs only from the airport to the hotel or hospital and back to the airport, one time only are also the responsibility of the CONTRACTOR. The CONTRACTOR will follow, at a minimum, the DEPARTMENT's criteria for coverage of food, lodging, transportation, and airfare expenses.

11. NON-CONTRACTOR PRIOR AUTHORIZATIONS

a. PRIOR AUTHORIZATIONS - GENERAL

The CONTRACTOR shall honor prior authorizations for organ transplantations and any other ongoing services initiated by the DEPARTMENT while the Enrollee was covered under Medicaid fee-for-service until the Enrollee is evaluated by the CONTRACTOR and a new plan of care is established.

b. WHEN THE CONTRACTOR HAS NOT AUTHORIZED THE SERVICE AND THE PROVIDER IS NOT A PARTICIPATING PROVIDER

For services that require a prior authorization, the CONTRACTOR will pay the provider of the service at the Medicaid rate, if all of the following conditions are met:

1) the servicing provider is not a participating provider under contract with the CONTRACTOR; and

2) the DEPARTMENT issued a prior authorization for an Enrollee to the servicing provider; and

3) the servicing provider has completed the CONTRACTOR's appeals process without resolution of the claim, and has requested a hearing with

the State Formal Hearings Unit requesting payment for the services rendered; and

4) in the hearing process it is determined that the service rendered was a Medically Necessary service covered under this Contract, and that the CONTRACTOR will be responsible for payment of the claim.

F. CLARIFICATION OF PAYMENT RESPONSIBILITIES

1. COVERED SERVICES RECEIVED OUTSIDE CONTRACTOR's NETWORK BUT PAID BY CONTRACTOR

The CONTRACTOR will not be required to pay for Covered Services, defined in Attachment C, which the Enrollee receives from sources outside The CONTRACTOR's network, not arranged for and not authorized by the CONTRACTOR except as follows:

a. Emergency Services;
b. Court ordered services that are Covered Services defined in Attachment C and which have been coordinated with the CONTRACTOR; or
c. Cases where the Enrollee demonstrates that such services are Medically Necessary Covered Services and were unavailable from the CONTRACTOR.

2. PAYMENT TO NON-NETWORK PROVIDERS AND TO PROVIDERS OUT OF THE SERVICE AREA

Payment by the CONTRACTOR to an out-of-network provider for emergency services and/or to a provider out of the Service Area for services that are approved for payment by the CONTRACTOR shall not exceed the lower of the following rates applicable at the time the services were rendered to an Enrollee, unless there is a negotiated arrangement:

a. The usual charges made to the general public by the provider;
b. The rate equal to the applicable Medicaid fee-for-service rate; or
c. The rate agreed to by the CONTRACTOR and the provider.

3. WHEN COVERED SERVICES ARE NOT THE CONTRACTOR's RESPONSIBILITY

a. The CONTRACTOR is not responsible for payment when family planning services are obtained by an Enrollee from sources other than the CONTRACTOR.

b. The CONTRACTOR will not be required to provide, arrange for, or pay for Covered Services to Enrollees whose illness or injury results directly from a catastrophic occurrence or disaster, including, but not limited to, earthquakes or acts of war. The effective date of excluding such Covered Services will be the date specified by the Federal Government or the State of Utah that a Federal or State emergency exists or disaster has occurred.

4. THE DEPARTMENT's RESPONSIBILITY

Except as described in Attachment F (Rates and Rate-Related Terms) of this Contract, the DEPARTMENT will not be required to pay for any Covered Services under Attachment C which the Enrollee received from any sources outside the CONTRACTOR except for family planning services.

5. COVERED SERVICES PROVIDED BY THE DEPARTMENT OF HEALTH, DIVISION OF COMMUNITY AND FAMILY HEALTH SERVICES

For Enrollees who qualify for special services offered by or through the Department of Health, Division of Community and Family Health Services (DCFHS), the CONTRACTOR agrees to reimburse DCFHS at the standard Medicaid rate in effect at the time of service for one outpatient team evaluation and one follow-up visit for each Enrollee upon each instance that the Enrollee both becomes Medicaid eligible and selects the CONTRACTOR as its provider. The CONTRACTOR agrees to waive any prior authorization requirement for one outpatient team evaluation and one follow-up visit. The services provided in the outpatient team evaluation and follow-up visit for which the CONTRACTOR will reimburse DCFHS are limited to the services that the CONTRACTOR is otherwise obligated to provide under this Contract.

If the CONTRACTOR desires a more detailed agreement for additional services to be provided by or through DCFHS for children with special health care needs, the CONTRACTOR may subcontract with DCFHS. The CONTRACTOR agrees that the subcontract with DCFHS will acknowledge and address the specific needs of DCFHS as a government provider.

6. ENROLLEE TRANSITION BETWEEN MCOs, OR BETWEEN FEE-FOR-SERVICE AND CONTRACTOR

a. INPATIENT HOSPITAL

When an Enrollee is in an inpatient hospital setting and selects another MCO or becomes fee-for-service anytime prior to discharge from the hospital, the CONTRACTOR is financially responsible for the entire hospital stay including all services related to the hospital stay, i.e. physician, etc. The MCO in which the individual is enrolled when discharged from the hospital is financially responsible for services provided during the remainder of the month when the individual was discharged. If such individual is fee-for-service when discharged from the hospital, the DEPARTMENT is financially responsible for the remainder of the month when the individual was discharged. If a Medicaid eligible is fee-for-service when admitted to the hospital and selects an MCO anytime prior to discharge from the hospital, the DEPARTMENT is financially responsible for the entire hospital stay including all services related to the hospital stay, i.e. physician, etc. The MCO in which the individual is enrolled when discharged from the hospital is financially responsible for services provided during the remainder of the month when the individual was discharged. When an Enrollee is in an inpatient hospital setting at the time the CONTRACTOR terminates this Contract and the Enrollee selects another MCO

anytime prior to discharge from the hospital, the receiving MCO is financially responsible for the hospital stay beginning 30 days after termination of the Contract.

b. HOME HEALTH SERVICES

Medicaid clients who are under fee-for-service or are enrolled in an MCO other than this MCO and are receiving home health services from an agency not contracting with the CONTRACTOR will be transitioned to the CONTRACTOR's home health agency. The CONTRACTOR is responsible for payment, not to exceed Medicaid payment, for a period not to exceed seven calendar days, unless the CONTRACTOR and the home health agency agree to another time period in writing, after the CONTRACTOR notifies the non-participating home health agency of the change in status or the non-participating home health agency notifies the CONTRACTOR that services are being provided by its agency. The CONTRACTOR will assess the needs of the Enrollee at the time the CONTRACTOR provides the orientation to the Enrollee.

The CONTRACTOR will include the Enrollee in developing the plan of care to be provided by the CONTRACTOR's home health agency before the transition is complete. The CONTRACTOR will address Enrollee's concerns regarding Covered Services provided by the CONTRACTOR's home health agency before the new plan of care is implemented.

c. MEDICAL EQUIPMENT

When medical equipment is ordered for an Enrollee by the CONTRACTOR and the Enrollee enrolls in a different MCO or becomes fee-for-service before receiving the equipment, the CONTRACTOR is responsible for payment of such equipment. When medical equipment is ordered for a Medicaid eligible by the DEPARTMENT and the Enrollee selects an MCO, the DEPARTMENT is responsible for payment of such equipment. Medical equipment includes, but is not limited to, specialized wheelchairs or attachments, prostheses, and other equipment designed or modified for an individual client. Any attachments to the equipment, replacements, or new equipment is the responsibility of the MCO in which the client is enrolled at the time such equipment is ordered.

7. SURVEYS

All surveys required under this Contract will be funded by the CONTRACTOR unless funded by another source such as the Utah Department of Health, Office of Health Care Statistics. The surveys must be conducted by an independent vendor mutually agreed upon by the DEPARTMENT and CONTRACTOR. The DEPARTMENT or designee will analyze the results of the surveys. Before publishing articles, data, reports, etc. related to surveys the DEPARTMENT will provide drafts of such material to the CONTRACTOR for review and feedback. The CONTRACTOR will not be responsible for the costs incurred for such publishing by the DEPARTMENT.

ARTICLE V - ENROLLEE RIGHTS/SERVICES

A. MEMBER SERVICES FUNCTION

The CONTRACTOR must operate a Member Services function during regular business hours. Ongoing training, as necessary, shall be provided by the CONTRACTOR to ensure that the Member Services staff is conversant in the CONTRACTOR's policies and procedures as they relate to Enrollees. At a minimum, Member Services staff must be responsible for the following:

1. Explaining the CONTRACTOR's rules for obtaining services;

2. Assisting Enrollees to select or change primary care providers;

3. Fielding and responding to Enrollee questions and complaints and grievances.

The CONTRACTOR shall conduct ongoing assessment of its orientation staff to determine staff member's understanding of the MCO and its Medicaid managed care policies and provide training, as needed.

B. ENROLLEE LIABILITY

1. The CONTRACTOR will not hold an Enrollee liable for the following:

   a. The debts of the CONTRACTOR if it should become insolvent.

   b. Payment for services provided by the CONTRACTOR if the CONTRACTOR has not received payment from the DEPARTMENT for the services, or if the provider, under contract with the CONTRACTOR, fails to receive payment from the CONTRACTOR.

   c. The payments to providers that furnish Covered Services under a contract or other arrangement with the CONTRACTOR that are in excess of the amount that normally would be paid by the Enrollee if the service had been received directly from the CONTRACTOR.

C. GENERAL INFORMATION TO BE PROVIDED TO ENROLLEES

The CONTRACTOR will make the following information available to Enrollees and potential Enrollees on request:

1. The identity, locations, qualification, and availability of participating providers (at a minimum, area of specialty, board certification, and any special areas of expertise must be available that would be helpful to individuals deciding whether to enroll with the CONTRACTOR);

2. The rights and responsibilities of Enrollees;

3. The procedures available to Enrollees and providers to challenge or appeal the failure of

the CONTRACTOR to cover a services; and

4. All items and services that are available to Enrollees that are covered either directly or through a method of referral or prior authorization.

D. ACCESS

1. IN GENERAL

The CONTRACTOR shall provide the DEPARTMENT and the Department of Health and Human Services, Centers for Medicare and Medicaid, adequate assurances that the CONTRACTOR, with respect to a service area, has the capacity to serve the expected enrollment in such service area, including assurances that the CONTRACTOR offers an appropriate range of services and access to preventive and primary care services for the population expected to enroll in such service area, and maintains a sufficient number, mix and geographic distribution of providers of services.

The CONTRACTOR will provide services which are accessible to Enrollees and appropriate in terms of timeliness, amount, duration, and scope.

2. SPECIFIC PROVISIONS

a. ELIMINATION OF ACCESS PROBLEMS CAUSED BY GEOGRAPHIC, CULTURAL AND LANGUAGE BARRIERS AND PHYSICAL DISABILITIES

The CONTRACTOR will minimize, with a goal to eliminate, Enrollee's access problems due to geographic, cultural and language barriers, and physical disabilities. The CONTRACTOR will provide assistance to Enrollees who have communication impediments or impairments to facilitate proper diagnosis and treatment. The CONTRACTOR must guarantee equal access to services and benefits for all Enrollees by making available interpreters, Telecommunication Devices for the Deaf (TDD), and other auxiliary aids to all Enrollees as needed. The CONTRACTOR will accommodate Enrollees with physical and other disabilities in accordance with the American Disabilities Act of 1990 (ADA), as amended. If the CONTRACTOR's facilities are not accessible to Enrollees with physical disabilities, the CONTRACTOR will provide services in other accessible locations.

b. INTERPRETIVE SERVICES

The CONTRACTOR will provide interpretive services for languages on an as needed basis. These requirements will extend to both in-person and telephone communications to ensure that Enrollees are able to communicate with the CONTRACTOR and CONTRACTOR's providers and receive Covered Services. Professional interpreters will be used when needed where technical, medical, or treatment information is to be discussed, or where use of a Family Member or friend as interpreter is inappropriate. A family member or friend may be used as an interpreter if this method is requested by the patient, and the use of such a

person would not compromise the effectiveness of services or violate the patient's confidentiality, and the patient is advised that a free interpreter is available.

c. CULTURAL COMPETENCE REQUIREMENTS

The CONTRACTOR shall incorporate in its policies, administration, and delivery of services the values of honoring Enrollee's beliefs; being sensitive to cultural diversity; and promoting attitudes and interpersonal communication styles with staff and providers which respect Enrollees' cultural backgrounds. The CONTRACTOR must foster cultural competency among its providers. Culturally competent care is care given by a provider who can communicate with the Enrollee and provide care with sensitivity, understanding, and respect for the Enrollee's culture, background and beliefs. The CONTRACTOR shall strive to ensure its providers provide culturally sensitive services to Enrollees. These services shall include but are not limited to providing training to providers regarding how to promote the benefits of health care services as well as training about health care attitudes, beliefs, and practices that affect access to health care services.

d. NO RESTRICTIONS OF PROVIDER's ABILITY TO ADVISE AND COUNSEL

The CONTRACTOR may not restrict a health care provider's ability to advise and counsel Enrollees about Medically Necessary treatment options. All contracting providers acting within his or her scope of practice, must be permitted to freely advise an Enrollee about his or her health status and discuss appropriate medical care or treatment for that condition or disease regardless of whether the care or treatment is a Covered Service.

e. WAITING TIME BENCHMARKS

The CONTRACTOR will adopt benchmarks for waiting times for physician appointments as follows:

Waiting Time for Appointments

1) Primary Care Providers:
   - within 30 days for routine, non-urgent appointments
   - within 60 days for school physicals
   - within 2 days for urgent, symptomatic, but not life-threatening care (care that can be treated in the doctor's office)

2) Specialists:
   - within 30 days for non-urgent
   - within 2 days for urgent, symptomatic, but not life-threatening care (care that can be treated in a doctor's office)

These benchmarks do not apply to appointments for regularly scheduled visits to monitor a chronic medical condition if the schedule calls for visits less frequently than once every month.

E. CHOICE

The CONTRACTOR must allow Enrollees the opportunity to select a participating Primary Care Provider. This excludes clients who are under the Restriction Program. If an Enrollee's Primary Care Provider ceases to participate in the CONTRACTOR's network, the CONTRACTOR must offer the Enrollee the opportunity to select a new Primary Care Provider.

F. COORDINATION

1. IN GENERAL

The CONTRACTOR will ensure access to a coordinated, comprehensive and continuous array of needed services through coordination with other appropriate entities. The CONTRACTOR's providers are not responsible for rendering waiver services.

2. PREPAID MENTAL HEALTH PLAN

a. When an Enrollee is also enrolled in a Prepaid Mental Health Plan, the CONTRACTOR and Prepaid Mental Health Plan will share appropriate information regarding the Enrollee's health care to ensure coordination of physical and mental health care services.

b. The CONTRACTOR will educate its subcontracted providers regarding an effective model of coordination such as the model developed by the PMHP/MCO Coordination of Care Committee. The CONTRACTOR will ensure its subcontracted providers coordinate the provision of physical health care services with mental health care services as appropriate.

c. When an Enrollee is also enrolled in a Prepaid Mental Health Plan, the CONTRACTOR will not delay an Enrollee's access to needed services in disputes regarding responsibility for payment. Payment issues should be addressed only after needed services are rendered. As described in Attachment B, IV (Benefits), Section E (Clarification of Covered Services), Subsection 8 of this Contract, the independent panel established by the DEPARTMENT will assist in adjudicating such disputes when requested to do so by either party.

d. Clients enrolled in the MCO and a Prepaid Mental Health Plan who due to a psychiatric condition require lab, radiology and similar outpatient services covered under this Contract, but prescribed by the Prepaid Mental Health Plan physician, will have access to such services in a timely fashion. The CONTRACTOR and Prepaid Mental Health Plan will reduce or eliminate unnecessary barriers that may delay the Enrollee's access to these critical services.

3. DOMESTIC VIOLENCE

The CONTRACTOR will ensure that providers are knowledgeable about methods to detect domestic violence and about resources in the community to which they can refer patients.

4. RESTRICTION PCP

The CONTRACTOR will ensure that Enrollees who are on the Restriction Program are linked to a primary care physician (PCP) who agrees to serve as a Restriction PCP. The Restriction PCP must agree to the following:

a. manage all of the Enrollee's medical care;

b. educate the Enrollee regarding appropriate use of medical services;

c. provide a referral to another physician when needed care is not within the PCP's field of expertise, or when for some other reason the care cannot be provided by the PCP;

d. must be telephonically available 24 hours a day, seven days a week (or make certain a provider of comparable specialty is available) for urgent/emergent medical situations to assure the availability of prompt, quality, medical services and continuity of care;

e. manage acute and/or chronic long term pain through a variety of services or treatment options including office calls, medication administration, physical therapy, counseling and mental health referral with emphasis on teaching Enrollees to manage their pain by adapting actions and behaviors;

f. approve or deny drugs prescribed by other providers when contacted by the pharmacy to which the Enrollee is restricted;

g. work with the Restriction pharmacy, specialists, dentists, etc. sharing pertinent information regarding the Enrollee; and

h. provide information to the DEPARTMENT's Restriction staff that will help assess Restriction Enrollees' progress and that may include periodic written or telephonic evaluations when requested by the Restriction staff.

If the Restricted Enrollee's PCP chooses to no longer serve as the Enrollee's PCP, the CONTRACTOR must assist the Enrollee in finding a new PCP and coordinate with the DEPARTMENT's Restriction staff.

If a Restriction PCP ceases participation with the CONTRACTOR, the CONTRACTOR must communicate this immediately to the DEPARTMENT's Restriction staff. The CONTRACTOR must assist all affected Enrollees in finding a new PCP and notify the DEPARTMENT when the new PCP is selected.

G. BILLING ENROLLEES

1. IN GENERAL

Except as provided herein Attachment B. Article V (Enrollee Rights/Services), Section G (Billing Enrollees). subsection 2, no claim for payment will be made at any time by the

CONTRACTOR or its providers to an Enrollee accepted by that provider as an Enrollee for any Covered Service. When a provider accepts an Enrollee as a patient he or she will look solely to the CONTRACTOR and any third party coverage for reimbursement. If the provider fails to receive payment from the CONTRACTOR, the Enrollee cannot be held responsible for these payments.

2. CIRCUMSTANCES WHEN AN ENROLLEE MAY BE BILLED

An Enrollee may in certain circumstances be billed by the provider for non-Covered Services and/or for unpaid Medicaid co-payments or Medicaid co-insurance. A non-Covered Service is one that is not covered under this Contract, or includes special features or characteristics that are desired by the Enrollee, such as more expensive eyeglass frames, hearing aids, custom wheelchairs, etc., but do not meet the Medical Necessity criteria for amount, duration, and scope as set forth in the Utah State Plan. The DEPARTMENT will specify to the CONTRACTOR the extent of Covered Services and items under the Contract, as well as services not covered under the Contract but provided by Medicaid on a fee-for-service basis that would effect the CONTRACTOR's Covered Services. An Enrollee may be billed for a service not covered under this Contract and/or for unpaid Medicaid co-payment or co-insurance only when all of the following conditions are met:

a. the provider has an established policy for billing all patients for services not covered by a third party and/or for billing all patients for unpaid co-payment or co-insurance (non-Covered Services cannot be billed only to Enrollees.);

b. the provider has informed the Enrollee of its policy and the services and items that are not covered under this Contract and/or Medicaid co-payment or co insurance requirements and included this information in the Enrollee's member handbook;

c. the provider has advised the Enrollee prior to rendering the service that the service is not covered under this Contract and/or that a Medicaid co-payment or co-insurance is required and that the Enrollee will be personally responsible for making payment; and

d. in the case of non-Covered Services, the Enrollee agrees to be personally responsible for the payment of the non-Covered Service and an agreement is made in writing between the provider and the Enrollee which details the service and the amount to be paid by the Enrollee.

3. CONTRACTOR MAY NOT HOLD ENROLLEE's MEDICAID CARD

The CONTRACTOR or its providers will not hold the Enrollee's Medicaid card as guarantee of payment by the Enrollee. nor may any other restrictions be placed upon the Enrollee.

4. CRIMINAL PENALTIES

Criminal penalties shall be imposed on MCO providers as authorized under section

1128B(d)(1)of the Social Security Act if the provider knowingly and willfully charges an Enrollee at a rate other than those allowed under this Contract.

H. SURVEY REQUIREMENTS

Surveys will be conducted of the CONTRACTOR's Enrollees that will include questions about Enrollees' perceptions of access to and the quality of care received through the CONTRACTOR. The survey process, including the survey instrument, will be standardized and developed collaboratively among the DEPARTMENT and all contracting MCOs. The DEPARTMENT will analyze the results of the surveys. The CONTRACTOR's quality assurance committee will review the results of the surveys, identify areas needing improvement, outline action steps to follow up on findings, and inform (at a minimum), subcontractors, and member and provider services staff, when applicable.

1. GENERAL POPULATION SURVEY

At least every two years, the CONTRACTOR in conjunction with the DEPARTMENT will survey a sample of its general population Enrollees; i.e., Enrollees who do not meet the definition of those with special health care needs.

2. SPECIAL NEEDS SURVEY

At least every two years, the CONTRACTOR in conjunction with the DEPARTMENT will survey a sample of Enrollees with special health care needs.

ARTICLE VI - GRIEVANCE PROCEDURES

A. IN GENERAL

The CONTRACTOR will maintain a system for reviewing and adjudicating complaints and grievances by Enrollees and providers. The CONTRACTOR's complaint and grievance procedures must permit an Enrollee, or provider on behalf of an Enrollee, to challenge the denials of coverage of medical assistance or denials of payment for Covered Services. The CONTRACTOR will submit such grievance plans and procedures to the DEPARTMENT for approval prior to instituting or changing such procedures. Such procedures will provide for expeditious resolution of complaints and grievances by the CONTRACTOR's personnel who have authority to correct problems. The CONTRACTOR shall ensure that each Enrollee with limited English proficiency shall have the right to receive oral interpreter services without charge to the Enrollee at each stage of the CONTRACTOR's complaint and grievance process, including final determination. The CONTRACTOR shall separately track complaints and grievances that are related to Children with Special Health Care Needs and those related to Non-Traditional Medicaid Enrollees.

B. NONDISCRIMINATION

The CONTRACTOR shall designate a nondiscrimination coordinator who will 1) ensure the CONTRACTOR complies with Federal Laws and Regulations regarding nondiscrimination, and 2) take complaints and grievances from Enrollees alleging nondiscrimination violations based on

race, color, national origin, disability, or age. The nondiscrimination coordinator may also handle complaints regarding the violation of other civil rights (sex and religion) as other Federal laws and Regulations protect against these forms of discrimination. The CONTRACTOR will develop and implement a written method of administration to assure that the CONTRACTOR's programs, activities, services, and benefits are equally available to all persons without regard to race, color, national origin, disability, or age.

C. MINIMUM REQUIREMENTS OF GRIEVANCE PROCEDURES

At a minimum, the CONTRACTOR's complaint and grievance procedures must include

1. definitions of complaints and grievance;

2. details of how, when, where and with whom an Enrollee or provider may file a grievance;

3. assurances of the participation of individuals with authority to take corrective action;

4. responsibilities of the various components and staff of the organization;

5. a description of the process for timely review, prompt (45 days) resolution of complaints and grievances;

6. details of an appeal process; and

7. a provision stating that during the pendency of any grievance procedure or an appeal of such grievances, the Enrollee will remain enrolled except as otherwise stated in this Contract.

D. FINAL REVIEW BY DEPARTMENT

When an Enrollee or provider has exhausted the CONTRACTOR's grievance process and a final decision has been made, the CONTRACTOR must provide written notification to the party who initiated the grievance of the grievance's outcome and explain in clear terms a detailed reason for the denial.

The CONTRACTOR must provide notification to Enrollees and providers that the final decision of the CONTRACTOR may be appealed to the DEPARTMENT and will give to the Enrollee or provider the DEPARTMENT's form to request a formal hearing with the DEPARTMENT. The MCO must inform the Enrollee or provider the time frame for filing an appeal with the DEPARTMENT. The formal hearing with the DEPARTMENT is a de novo hearing. If the Enrollee or provider request a formal hearing with the DEPARTMENT, all parties to the formal hearing agree to be bound by the DEPARTMENT's decision until any judicial reviews are completed and are in the Enrollee's or provider's favor. Any decision made by the DEPARTMENT pursuant to the hearing shall be subject to appeal rights as provided by State and Federal laws and rules.

ARTICLE VII - OTHER REQUIREMENTS

A. COMPLIANCE WITH PUBLIC HEALTH SERVICE ACT

The CONTRACTOR will comply with all requirements of Section 1301 to and including 1318 of the Public Health Service Act, as applicable. The CONTRACTOR will provide verification of such compliance to the DEPARTMENT upon the DEPARTMENT's request.

B. COMPLIANCE WITH OBRA'90 PROVISION AND 42 CFR 434.28

The CONTRACTOR will comply with the OBRA '90 provision which requires an MCO provide patients with information regarding their rights under State law to make decisions about their health care including the right to execute a living will or to grant power of attorney to another individual.

The CONTRACTOR will comply with the requirements of 42 CFR 434.28 relating to maintaining written Advance Directives as outlined under Subpart I of 489.100 through 489.102.

C. FRAUD AND ABUSE REQUIREMENTS

The CONTRACTOR must have a compliance program to identify and refer suspected fraud and abuse activities. The compliance program must outline the CONTRACTOR's internal processes for identifying fraud and abuse. The CONTRACTOR agrees to abide by Federal and/or State fraud and abuse requirements including, but not limited to, the following:

1. Refer in writing to the DEPARTMENT all detected incidents of potential fraud or abuse on the part of providers of services to Enrollees or to other patients.

2. Refer in writing to the DEPARTMENT all detected incidents of patient fraud or abuse involving Covered Services provided which are paid for in whole, or in part, by the DEPARTMENT.

3. Refer in writing to the DEPARTMENT the names and Medicaid ID numbers of those Enrollees that the CONTRACTOR suspects of inappropriate utilization of services, and the nature of the suspected inappropriate utilization.

4. Inform the DEPARTMENT in writing when a provider is removed from the CONTRACTOR's panel for reasons relating to suspected fraud, abuse or quality of care concerns.

5. The CONTRACTOR may not employ or subcontract with any sanctioned provider. The DEPARTMENT shall notify the CONTRACTOR how to access information on providers sanctioned by Medicaid or Medicare. It is the responsibility of the CONTRACTOR to keep apprized of sanctioned providers. The CONTRACTOR may not employ or subcontract with any provider who is an ineligible entity as defined under the State Medicaid Manual Section 2086.16. This section is available upon request. The CONTRACTOR will attest that the entities listed below are not involved with the CONTRACTOR. Entities that must be excluded -

a. Entities that could be excluded under section 1128(b)(8) of the Social Security Act (the Act)~these are entities in which a person who is an officer, director, agent, or managing employee of the entity, or a person who has a direct or indirect ownership or control interest of 5% or more in the entity and has been convicted of the following crimes:

   1) any criminal offense related to the delivery of a Medicare or Medicaid item or service (see section 1128(a)(l) of the Act);
   2) patient abuse (section 1128(a)(2));
   3) fraud (1128(b)(l));
   4) obstruction of an investigation (1128(b)(2)); or
   5) offenses related to controlled substances (1128(b)(3)).

b. Entities that have a direct or indirect substantial contractual relationship with an individual or entity listed in subsection "a" above-- a substantial contractual relationship is defined as any contractual relationship which provides for one or more of the following:

   1) the administration, management, or provision of medical services;
   2) the establishment of policies pertaining to the administration, management or provision of medical services; or
   3) the provision of operational support for the administration, management, or provision of medical services.

c. Entities which employ, contract with, or contract through any individual or entity that is excluded from Medicaid participation under Section 1128 or Section 1128A of the Act, for the provision of health care, utilization review, medical social work or administration services.

D. DISCLOSURE OF OWNERSHIP AND CONTROL INFORMATION

The CONTRACTOR agrees to meet the requirements of 42 CFR 455, Subpart B related to disclosure by the CONTRACTOR of ownership and control information.

E. SAFEGUARDING CONFIDENTIAL INFORMATION ON ENROLLEES

The CONTRACTOR agrees that information about Enrollees is confidential information and agrees to safeguard all confidential information and conform to the requirements set forth in 42CFR, Part 431, Subpart F as well as all other applicable Federal and State confidentiality requirements. The CONTRACTOR must be in compliance with the privacy regulations issued under the Health Insurance Portability and Accountability Act (HIPAA) of 1996 when they go into effect.

F. DISCLOSURE OF PROVIDER INCENTIVE PLANS

The CONTRACTOR must submit to the DEPARTMENT information on its physician incentive plans as listed in 42 CFR 417.479(h)(l) and summarized in this Article VII, Section F, Subsections 1 through 5, by May 1 of each year. The CONTRACTOR must provide to the

DEPARTMENT the enrollee/disenrollee survey results when beneficiary surveys are required as specified in 42 CFR 417.479(g) and summarized in this Article VII, Section F, Subsection 7, by October 1 or three months after the end of the Contract year. The CONTRACTOR must submit to the DEPARTMENT information on capitation payments paid to primary care physicians as specified in 42 CFR 417.479(h)(l)(vi).

Per 42 CFR 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 Enrollee.

The CONTRACTOR may operate a physician incentive plan only if the stop-loss protection, Enrollee survey, and disclosure requirements are met. The CONTRACTOR must disclose to the DEPARTMENT the following information on provider incentive plans in sufficient detail to determine whether the incentive plan complies with the regulatory requirements. The disclosure must contain:

1. Whether services not furnished by the physician or physician group are covered by the incentive plan. If only the services furnished by the physician or physician group are covered by the incentive plan, disclosure of other aspects of the plan need not be made.

2. The type of incentive arrangement (i.e., withhold, bonus, capitation).

3. If the incentive plan involves a withhold or bonus, the percent of the withhold or bonus.

4. Proof that the physician or physician group has adequate stop-loss protection, including the amount and type of stop-loss protection.

5. The panel size and, if patients are pooled; the method used.

6. To the extent provided for in the Department of Health and Human Services, Centers for Medicare and Medicaid Services' (CMS) implementation guidelines, capitation payments paid to primary care physicians for the most recent year broken down by percent for primary care services, referral services to specialists, and hospital and other types of provider services (i.e., nursing home and home health agency) for capitated physicians or physician groups.

7. In the case of those prepaid plans that are required to conduct beneficiary surveys, the survey results. (The CONTRACTOR must conduct a customer satisfaction of both Enrollees and disenrollees if any physicians or physicians groups contracting with the CONTRACTOR are placed at substantial financial risk for referral services. The survey must include either all current Enrollees and those who have disenrolled in the past twelve months, or a sample of these same Enrollees and disenrollees. Recognizing that different questions are asked of the disenrollees than those asked of Enrollees, the same survey cannot be used for both populations.)
   The CONTRACTOR must disclose this information to the DEPARTMENT (1) prior to approval of its Contract or agreement and (2) upon the Contract or agreements anniversary or renewal effective date. The CONTRACTOR must provide the capitation data required (see 6 above) for the previous Contract year to the DEPARTMENT three months after the end of the Contract year. The CONTRACTOR will provide to the

Enrollee upon request whether the CONTRACTOR uses a physician incentive plan that affects the use of referral services, the type of incentive arrangement, whether stop-loss protection is provided, and the survey results of any enrollee/disenrollee surveys conducted.

G. DEBARRED OR SUSPENDED INDIVIDUALS

Under Section 1921(d)(l) of the Social Security Act, the CONTRACTOR may not knowingly have a director, officer, partner, or person with beneficial ownership of more than 5% of the CONTRACTOR's equity who has been debarred or suspended by any federal agency. The CONTRACTOR may not have an employment, consulting, or any other agreement with a debarred or suspended person for the provision of items or services that are significant and material to meeting the provisions under this Contract.

The CONTRACTOR must certify to the DEPARTMENT that the requirements under Section 1921(d)(l) of the Social Security Act are met prior to the effective date of this Contract and at any time there is a change from the last such certification.

H. CMS CONSENT REQUIRED

If the Department of Health and Human Services, Centers for Medicare and Medicaid (CMS) directs the DEPARTMENT to terminate this Contract, the DEPARTMENT will not be permitted to renew this Contract without CMS consent.

ARTICLE VIII - PAYMENTS

A. NON-RISK CONTRACT

This Contract is a non-risk contract as described in 42 CFR 447.362. Aggregate payments made to the CONTRACTOR may not exceed what the DEPARTMENT would have paid, on a fee-for-service basis, for the services actually furnished to recipients. The DEPARTMENT will reimburse the CONTRACTOR based on their paid claims plus 9% of paid claims for administration.

B. PAYMENT METHODOLOGY

The payment methodology is described in Attachment F of this Contract.

C. CONTRACT MAXIMUM

In no event will the aggregate amount of payments to the CONTRACTOR exceed the Contract maximum amount. If payments to the CONTRACTOR approach or exceed the Contract amount before the renewal date of the Contract, the DEPARTMENT shall execute a Contract amendment to increase the Contract amount within 30 calendar days of the date the Contract amount is exceeded.

D. MEDICARE

1. PAYMENT OF MEDICARE PART B PREMIUMS

The DEPARTMENT will pay the Medicare Part B premium for each Enrollee who is on Medicare. The Enrollee will assign to the CONTRACTOR his or her Medicare reimbursement for benefits received under Medicare. The Eligibility Transmission includes and identifies those Enrollees who are covered under Medicare.

2. PAYMENT OF MEDICARE DEDUCTIBLE AND COINSURANCE

The DEPARTMENT's financial obligation under this Contract for Enrollees who are covered by both Medicare and the MCO is limited to the Medicare Part B premium and the CONTRACTOR premium. The CONTRACTOR is responsible for payment of the Medicare deductible and coinsurance up to the CONTRACTOR's allowed amount for Enrollees when a service is paid for by Medicare whether or not the service is covered under this Contract. The CONTRACTOR is responsible for payment whether or not the Medicare covered service is rendered by a network provider or has been authorized by the CONTRACTOR. If a Medicare covered service is rendered by an out-of-network Medicare provider or a non-Medicare participating provider, the CONTRACTOR is responsible to pay the lower of the coinsurance/deductible and the CONTRACTOR's allowed amount. Attachment E, Table 2, will be used to identify the total cost to the CONTRACTOR of providing care for Enrollees who are also covered by Medicare.

3. MUST NOT BALANCE BILL ENROLLEES

The CONTRACTOR or its providers will not Balance Bill the Enrollee and will consider reimbursement from Medicare and from the CONTRACTOR as payment in full.

D. THIRD PARTY LIABILITY (COORDINATION OF BENEFITS)

The DEPARTMENT will provide the CONTRACTOR a monthly listing of Enrollees covered under the Buy-out Program, including the premium amount paid by the DEPARTMENT.

1. TPL COLLECTIONS

The CONTRACTOR will be responsible to coordinate benefits and collect third party liability (TPL). The CONTRACTOR will keep TPL collections. The DEPARTMENT will set rates net of expected TPL collections excluding the lump sum rate set for deliveries. The rate set for deliveries is the maximum amount the DEPARTMENT will pay the CONTRACTOR for each delivery. The CONTRACTOR must attempt to collect TPL before the DEPARTMENT will finalize payment for the lump sum delivery. The DHCF audit staff will monitor collections to ensure the CONTRACTOR is making a good faith effort to pursue TPL. The DEPARTMENT will properly account for TPL in its rate structure.

2. DUPLICATION OF BENEFITS

This provision applies when, under another health insurance plan such as a prepaid plan, insurance contract, mutual benefit association or employer's self-funded group health and welfare program, etc., an Enrollee is entitled to any benefits that would totally or partially duplicate the benefits that the CONTRACTOR is obligated to provide under this Contract. Duplication exists when (I) the CONTRACTOR has a duty to provide,

arrange for or pay for the cost of Covered Services, and (2) another health insurance plan, pursuant to its own terms, has a duty to provide, arrange for or pay for the same type of Covered Services regardless of whether the duty of the CONTRACTOR is to provide the Covered Services and the duty of the other health insurance plan is only to pay for the Covered Services. Under State and Federal laws and regulations, Medicaid funds are the last dollar source and all other health insurance plans as referred to above are primarily responsible for the costs of providing Covered Services.

3. RECONCILIATION OF OTHER TPL

In order to assist the CONTRACTOR in billing and collecting from other health insurance plans the DEPARTMENT will include on the Eligibility Transmission other health insurance plans of each Enrollee when it is known. The CONTRACTOR will review the Eligibility Transmission and will report to the Office of Recovery Services or the DEPARTMENT any TPL discrepancies identified within 30 working days of receipt of the Eligibility Transmission. The CONTRACTOR's report will include a listing of Enrollees that the CONTRACTOR has independently identified as being covered by another health insurance plan.

4. WHEN TPL IS DENIED

On a monthly basis, the CONTRACTOR will report to the Office of Recovery Services (ORS) claims that have been billed to other health care plans but have been denied which will include the following information:

a. patient name and Medicaid identification number
b. ICD-9-CM code;
c. procedure codes; and
d. insurance company.

5. NOTIFICATION OF PERSONAL INJURY CASES

The CONTRACTOR will be responsible to notify ORS of all personal injury cases, as defined by ORS and agreed to by the CONTRACTOR, no later than 30 days after the CONTRACTOR has received a "clean" claim. A clean claim is a claim that is ready to adjudicate. The following data elements will be provided by the CONTRACTOR to ORS:

a. patient name and Medicaid identification number
b. date of accident;
c. specific type of injury by ICD-9-CM code;
d. procedure codes; and
e. insurance company, if known.

6. ORS TO PURSUE COLLECTIONS

ORS will pursue collection on all claims described in Attachment B, Article VIII (Payments), Section D, Subsections 4 and 5 of this Contract. The DEPARTMENT will retain, for administrative costs, one third of the collections received for the period during

which medical services were provided by the CONTRACTOR, and remit the balance to the CONTRACTOR.

7. INSURANCE BUY-OUT PROGRAM

The Insurance Buy-out Program is an optional program in which the DEPARTMENT purchases group health insurance for a recipient who is eligible for Medicaid when it is determined cost-effective for the Medicaid program to do so. The insurance buy-out process will be coordinated by the DEPARTMENT in cooperation with the Office of Recovery Services, and Medicaid eligibility workers. The CONTRACTOR will file claims against group MCOs first before claiming services against the CONTRACTOR or other MCOs.

8. CONTRACTOR MUST PAY PROVIDER ADMINISTRATIVE FEE FOR IMMUNIZATIONS

When an Enrollee has third party coverage for immunizations, the CONTRACTOR will pay the provider the administrative fee for providing the immunization and not require the provider to bill the third party as a cost avoidance method. The CONTRACTOR may choose to pursue the third party amount for the administrative fee after payment has been made to the provider.

E. THIRD PARTY RESPONSIBILITY (INCLUDING WORKER's COMPENSATION)

1. CONTRACTOR TO BILL USUAL AND CUSTOMARY CHARGES

When a third party has an obligation to pay for Covered Services provided by the CONTRACTOR to an Enrollee pursuant to this Contract, the CONTRACTOR will bill the third party for the usual and customary charges for Covered Services provided and costs incurred. Should any sum be recovered by the Enrollee or otherwise, from or on behalf of the person responsible for payment for the service, the CONTRACTOR will be paid out of such recovery for the charges for service provided and costs incurred by the CONTRACTOR.

2. THIRD PARTY's OBLIGATION TO PAY FOR COVERED SERVICES

Examples of situations where a third party has an obligation to pay for Covered Services provided by the CONTRACTOR are when (a) the Enrollee is injured by a person due to the negligent or intentional acts (or omissions) of the person; or (b) the Enrollee is eligible to receive payment through Worker's Compensation Insurance. If the Enrollee does not diligently seek such recovery, the CONTRACTOR may institute such rights that it may have.

3. FIRST DOLLAR COVERAGE FOR ACCIDENTS

In addition, both parties agree that the following will apply regarding first dollar coverage for accidents: if the injured party has additional insurance, primary coverage may be given to the motor insurance effective at the time of the accident. Once the motor vehicle policy is exhausted, the CONTRACTOR will be the secondary payer and pay for all of the Enrollee's Covered Services. If medical insurance does not exist, the

CONTRACTOR will be the primary payer for all Covered Services.

4. NOTIFICATION OF STOP-LOSS

The CONTRACTOR will provide ORS with quarterly updates of costs incurred by the CONTRACTOR when such costs exceed Stop Loss (reinsurance) provisions as defined in the Contract between the reinsurer and the CONTRACTOR.

F. CHANGES IN COVERED SERVICES

If Covered Services are amended under the provisions of Attachment B, Article IV (Benefits), Section C, Subsection 3 of this Contract, rates may be renegotiated.

ARTICLE IX - RECORDS, REPORTS AND AUDITS

A. FEDERALLY REQUIRED REPORTS

1. CHEC/EPSDT REPORTS

The CONTRACTOR agrees to act as a continuing care provider for the CHEC/EPSDT program in compliance with OBRA '89 and Social Security Act Sections 1902 (a)(43), 1905(a)(4)(B)and 1905 (r).

a. CHEC/EPSDT SCREENINGS

Annually, the CONTRACTOR will submit to the DEPARTMENT information on CHEC/EPSDT screenings to meet the Federal EPSDT reporting requirements (Form HCFA-416). The data will be in a mutually agreed upon format. The CHEC/EPSDT information is due December 31 for the prior federal fiscal year's data (October 1 through September 30).

b. IMMUNIZATION DATA

The CONTRACTOR will submit immunization data as part of the CHEC/EPSDT reporting. Enrollee name, Medicaid ID, type of immunization identified by procedure code, and date of immunization will be reported in the same format as the CHEC/EPSDT data.

2. DISCLOSURE OF PHYSICIAN INCENTIVE PLANS

The CONTRACTOR must submit to the DEPARTMENT information on its physician incentive plans as listed in 42 CFR 417.479(h)(l) [or Article VII - Other Requirements, F - Disclosure of Provider Incentive Plans, 1 through 5] by May 1 of each year. The CONTRACTOR must provide to the DEPARTMENT the enrollee/disenrollee survey results when beneficiary surveys are required as specified in 42 CFR 417.479(g) [or #7 under Article VII.F.] by October 1 or three months after the end of the Contract year. The CONTRACTOR must submit to the DEPARTMENT information on capitation payments paid to primary care physicians as specified in 42 CFR 417.479(h)(l)(vi).

B. PERIODIC REPORTS

1. ENROLLMENT, COST AND UTILIZATION REPORTS (ATTACHMENT E)

Enrollment, cost and utilization reports will be submitted on diskettes in Excel or Lotus and in the format specified in Attachment E. A hard copy of the report must be submitted as well. The DEPARTMENT will send to the CONTRACTOR a template of the Attachment E format on a diskette. The CONTRACTOR may not customize or change the report format. The financial information for these reports will be reported as defined in HCFA Publication 75, and if applicable, HCFA 15-1. The CONTRACTOR will certify in writing the accuracy and completeness, to the best of its knowledge, of all costs and utilization data provided to the DEPARTMENT on Attachment E.

Two Attachment E reports will be submitted covering dates of service for each Contract year.

a. Attachment E is due May 1 for the preceding six-month reporting period (July through December).

b. Attachment E is due November 1 for the preceding 12-month reporting period (July through June).

If necessary, the CONTRACTOR may request, in writing, an extension of the due date up to 30 days beyond the required due date. The DEPARTMENT will approve or deny the extension request writing within seven calendar days of receiving the request.

2. INTERPRETIVE SERVICES

Annually, on November 1, the CONTRACTOR will submit summary information about the use of interpretive services during the previous Contract year (July 1 through June 30). The information must include the following:

a. a list of all sources of interpreter services;
b. total expenditures for each language;
c. total expenditures for clinical versus administrative;
d. number of Enrollees who used interpretive services for each language;
e. number of services provided categorized by clinical versus administrative.

3. SEMI-ANNUAL REPORTS

The following semi-annual reports are due May 1 for the preceding six-month reporting period ending December 31 (July through December) and are due November 1 for the preceding six month period ending June 30 (January through June).

a. Organ Transplants: Report the total number of organ transplants by type of transplant.

b. Obstetrical Information: Report obstetrical information including

1) total number of obstetrical deliveries by aid category grouping;
2) total number of caesarean sections and total number of vaginal deliveries;
3) total number low birth weight infants; and
4) total number of Enrollees requiring prenatal hospital admission.

c. COMPLAINTS AND FORMAL GRIEVANCES

Separate reports of complaints/grievances are required for adults and children; and for Traditional Medicaid Plan Enrollees and Non-Traditional Plan Enrollees. Each report must distinguish between those Enrollees with special health care needs and the general population of children. Report summary information on the number of complaints/grievances by type of complaint/grievance and indicate the number that have been resolved. Include an analysis of the type and number of complaints/grievances received by the CONTRACTOR.

d. ABERRANT PHYSICIAN BEHAVIOR

Report summary information of corrective actions taken on physicians who have been identified by the CONTRACTOR as exhibiting aberrant physician behavior and the names of physicians who have been removed from the CONTRACTOR's network due to aberrant behavior. The summary shall include the reasons for the corrective action or removal.

4. ANNUAL QUALITY IMPROVEMENT PROGRAM DOCUMENTATION

Annually, the CONTRACTOR will submit to the DEPARTMENT the following documents:

a. the CONTRACTOR's quality improvement program description;
b. the CONTRACTOR's quality improvement work plan;
c. the CONTRACTOR's quality improvement work plan evaluation for previous calendar year.

These reports must be in the format developed by the DEPARTMENT and include signature(s) of approval by the CONTRACTOR's designated authorizing authority. Reports for each calendar year are due no later than March 31st of each year.

5. DOCUMENTS DUE PRIOR TO QUALITY MONITORING REVIEWS

The following documents are due at least 60 days prior to the DEPARTMENT's quality assurance monitoring review, or earlier on request, unless the DEPARTMENT has already received documents that are in effect:

a. the CONTRACTOR's most current (may be in draft stage) written quality improvement program description;

b. the CONTRACTOR's most current (may be in draft stage) annual quality improvement work plan;

c. the CONTRACTOR's most current (may be in draft stage) quality improvement work plan evaluation for the previous calendar year;

d. documentation of the CONTRACTOR's compliance to standards defined in the defined in the Utah MCO Quality Assurance Monitoring Plan (Attachment G).

e. all other information requested by the DEPARTMENT to facilitate the DEPARTMENT's review of the CONTRACTOR's compliance to standards defined in the Utah MCO Quality Assurance Monitoring Plan (Attachment G).

The above documents must show evidence of a well defined, organized program designed to improve client care.

6. IMPACT OF CO-PAYMENTS

The following semi-annual report is due May 1 for the preceding six-month reporting period ending April 30 (November of previous year through April of current year) and November 1 for the preceding six-month period ending October 31 (May through October of the current year):

Report shall document all instances when Enrollees have contacted the CONTRACTOR with a complaint about being denied services because they did not pay their Medicaid co-payment or co-insurance. For each instance, report the Enrollee's name, Medicaid ID, provider, and the service the Enrollee was scheduled to receive.

7. HEDIS

Audited Health Plan Employer Data and Information Set (HEDIS) performance measures will cover services rendered to Enrollees and will be reported as set forth in State rule by the Office of Health Data Analysis. For example, calendar year 1997 HEDIS measures will be reported in 1998.

8. ENCOUNTER DATA

Encounter data, as defined in the DEPARTMENT's "Encounter Records Technical Manual," is due (including all replacements) six months after the end of the quarter being reported. Encounter data will be submitted in accordance with the instructions detailed in the Encounter Records Technical Manual for dates of service beginning July 1, 1996. The CONTRACTOR must receive certification from an independent, credible vendor that their electronic submissions of encounter data are compliant with the Health Insurance Portability and Accountability Act (HIPAA) requirements. At a minimum, the CONTRACTOR must be HIPAA-compliant in the first four levels of HIPAA compliance: Level 1 - Integrity Testing, Level 2 - Requirement Testing, Level 3 - Balancing, and Level 4 - Situation Testing.

9. AUDIT OF ABORTIONS, STERILIZATIONS AND HYSTERECTOMIES

The CONTRACTOR must conduct an annual audit of abortion, hysterectomy and sterilization procedures performed by the CONTRACTOR's providers. The purpose of

the audit is to monitor compliance with federal and state requirements for the reimbursement of these procedures under Medicaid. The CONTRACTOR must audit all abortions and a sample of hysterectomy and sterilization procedures as defined by the DEPARTMENT.

On November 1 of each year, the CONTRACTOR will submit to the DEPARTMENT the following information on the results of the abortion, sterilization and hysterectomy audit for the previous calendar year.

For the sterilization and hysterectomy audit, submit documentation of the methodology used to pull the sample of sterilization and hysterectomies and include the sampling proportions.

In an Excel file, submit the following information for all abortions, the sample of sterilizations, and the sample of hysterectomies:

- client name
- Medicaid ID number
- procedure code
- date of service
- history/physical (yes/no)
- operative report (yes/no)
- pathology report (yes/no)
- consent form (yes/no)
- medical necessity criteria - hysterectomies only

When information is submitted electronically, the CONTRACTOR must use a secured electronic transmission process.

The DEPARTMENT will evaluate the results of the CONTRACTOR's audit and identify the cases that will require medical record submission. Medical record submission will be required for all abortions and a random sample of hysterectomy and sterilization cases. The DEPARTMENT will notify the CONTRACTOR in writing of the cases that will require medical record submission and the time line for the medical record submissions.

10. DEVELOPMENT OF NEW REPORTS

Any new reports/data requirements mandated by the DEPARTMENT will be mutually developed by the DEPARTMENT and the CONTRACTOR.

C. RECORD SYSTEM REQUIREMENTS

In accordance with Section 4752 of OBRA '90 (amended section 1903 (m)(2)(A) of the Social Security Act), the CONTRACTOR agrees to maintain sufficient patient encounter data to identify the physician who delivers Covered Services to Enrollees. The CONTRACTOR agrees to provide this encounter data, upon request of the DEPARTMENT, within 30 days of the request.

D. MEDICAL RECORDS

The CONTRACTOR agrees that medical records are considered confidential information and agrees to follow Federal and State confidentiality requirements.

The CONTRACTOR will require that its providers maintain a medical record keeping system through which all pertinent information relating to the medical management of the Enrollee is maintained, organized, and is readily available to appropriate professionals. Notwithstanding any other provision of this Contract to the contrary, medical records covering Enrollees will remain the property of the provider, and the provider will respect every Enrollee's privacy by restricting the use and disclosure of information in such records to purposes directly connected with the Enrollee's health care and administration of this Contract. The CONTRACTOR will use and disclose information pertaining to individual Enrollees and prospective Enrollees only for purposes directly connected with the administration of the Medicaid Program and this Contract.

E. AUDITS

1. RIGHT OF DEPARTMENT AND CMS TO AUDIT

The DEPARTMENT and the Department of Health and Human Services, Centers for Medicare and Medicaid Services may audit and inspect any financial records of the CONTRACTOR or its subcontractors relating (I) to the ability of the CONTRACTOR to bear the risk of potential financial losses, or (II) to evaluate services performed or determinations of amounts payable under the Contract.

2. INFORMATION TO DETERMINE ALLOWABLE COSTS

The CONTRACTOR will make available to the DEPARTMENT all reasonable and related financial, statistical, clinical or other information needed for the determination of allowable costs to the Medicaid program for "related party/home office" transactions as defined in HCFA 15-1. These records are to be made available in Utah or the CONTRACTOR will pay the increased cost (incremental travel, per diem, etc.) of auditing at the out-of-state location. The cost to the CONTRACTOR will include round-trip travel and two days per diem/lodging. Additional travel costs of the site audit will be shared equally by the CONTRACTOR and the DEPARTMENT.

3. MANAGEMENT AND UTILIZATION AUDITS

The MCO will allow the DEPARTMENT and the Department of Health and Human Services, Centers for Medicare and Medicaid Services, to perform audits for identification and collection of management data, including Enrollee satisfaction data, quality of care data, fraud-related data, abuse-related data, patient outcome data, and cost and utilization data, which will include patient profiles, exception reports, etc. The CONTRACTOR will provide all data required by the DEPARTMENT or the independent quality review examiners in performance of these audits. Prior to beginning any audit, the DEPARTMENT will give the CONTRACTOR reasonable notice of audit, and the DEPARTMENT will be responsible for costs of its auditors or representatives.

F. INDEPENDENT QUALITY REVIEW

1. IN GENERAL

Pursuant to Section 1932(c)(2)(A) of the Social Security Act the DEPARTMENT may provide for an annual external independent review conducted by a qualified independent entity of the quality outcomes and timeliness of and access to Covered Services. The CONTRACTOR will support the annual external independent review.

The DEPARTMENT will choose an agency to perform an annual independent quality review pursuant to federal law and will pay for such review. The CONTRACTOR will maintain all clinical and administrative records for use by the quality review contractor. The CONTRACTOR agrees to support quality assurance reviews, focused studies and other projects performed for the DEPARTMENT by the external quality review organization (EQRO). The purpose of the reviews and studies are to comply with federal requirements for an annual independent audit of the quality outcomes and timeliness of, and access to, Covered Services. The external independent reviews are conducted by the EQRO, with the advice, assistance, and cooperation of a planning team composed of representatives from the CONTRACTOR, the EQRO and the DEPARTMENT with final approval by the DEPARTMENT.

2. SPECIFIC REQUIREMENTS

a. LIAISON FOR ROUTINE COMMUNICATION

The CONTRACTOR will designate an individual to serve as liaison with the EQRO for routine communication with the EQRO.

b. REPRESENTATIVE TO ASSIST WITH PROJECTS

The CONTRACTOR will designate a minimum of two representatives (unless one individual can service both functions) to serve on the planning team for each EQRO project. Representatives will include a quality improvement representative and a data representative. The planning team is a joint collaborative forum between DEPARTMENT staff, the EQRO and the CONTRACTOR. The role of the planning team is to participate in the process and completion of EQRO projects.

c. COPIES AND ON-SITE ACCESS

The CONTRACTOR will be responsible for obtaining copies of Enrollee information and facilitating on-site access to Enrollee information as needed by the EQRO. Such information will be used to plan and conduct projects and to investigate complaints and grievances. Any associated copying costs are the responsibility of the CONTRACTOR. Enrollee information includes medical records, administrative data such as, but not limited to, enrollment information and claims, nurses' notes, medical logs, etc. of the CONTRACTOR or its providers.

d. FORMAT OF ENROLLEE FILES

The CONTRACTOR will provide Enrollee information in a mutually agreed upon format compatible for the EQRO's use, and in a timely fashion to allow the EQRO to select cases for its review.

e. TIME-FRAME FOR PROVIDING DATA

The CONTRACTOR will provide data requests to the EQRO within 15 working days of the written request from the EQRO and will provide medical records within 30 working days of the written request from the EQRO. Requests for extensions of these time frames will be reviewed and approved or disapproved by the DEPARTMENT on a case-by-case basis.

f. WORK SPACE FOR ON-SITE REVIEWS

The CONTRACTOR will assure that the EQRO staff and consultants have adequate work space, access to a telephone and copy machines at the time of review. The review will be performed during agreed-upon hours.

g. STAFF ASSISTANCE DURING ON-SITE VISITS

The CONTRACTOR will assign appropriate person(s) to assist the EQRO personnel conduct the reviews during on-site visits and to participate in an informal discussion of screening observations at the end of each on-site visit, if necessary.

h. CONFIDENTIALITY

For information received from the EQRO, the CONTRACTOR will comply with the Department of Health and Human Services regulations relating to confidentiality of data and information (42 CFR Part 476.107 and 476.108).

ARTICLE X - SANCTIONS

The DEPARTMENT may impose intermediate sanctions on the CONTRACTOR if the CONTRACTOR defaults in any manner in the performance of any obligation under this Contract including but not limited to the following situations:

(1) the CONTRACTOR fails to substantially provide Medically Necessary Covered Services to Enrollees;

(2) the CONTRACTOR imposes premiums or charges Enrollees in excess of the premiums or charges permitted under this Contract;

(3) the CONTRACTOR acts to discriminate among Enrollees on the basis of their health status or requirements for health care services, including expulsion or refusal to re-enroll an individual, except as permitted by Title XIX, or engaging in any practice that would

reasonably be expected to have the effect of denying or discouraging enrollment with the MCO by potential Enrollees whose medical condition or history indicates a need for substantial future medical services;

(4) the CONTRACTOR misrepresents or falsifies information furnished to the Department of Health and Human Services, Centers for Medicare and Medicaid Services, the DEPARTMENT, an Enrollee, potential Enrollee or health care provider;

(5) the CONTRACTOR fails to comply with the physician incentive requirements under Section 1903(m)(2)(A)(x) of the Social Security Act.

(6) the CONTRACTOR distributed directly or through any agent or independent contractor marketing materials that contain false or misleading information.

The DEPARTMENT must follow the 1997 Balance Budget Act guidelines on the types of intermediate sanctions the DEPARTMENT may impose, including civil monetary penalties, the appointment of temporary management, and suspension of payment.

ARTICLE XI - TERMINATION OF THE CONTRACT

A. AUTOMATIC TERMINATION

This Contract will automatically terminate June 30, 2004.

B. OPTIONAL YEAR-END TERMINATION

At the end of each Contract year, either party may terminate the Contract without cause for subsequent years by giving the other party written notice of termination at least 90 days prior to the end of the Contract year (July 1 through June 30).

C. TERMINATION FOR FAILURE TO AGREE UPON RATES

At least 60 days prior to the end of each Contract year, the parties will meet and negotiate in good faith the rates (Attachment F) applicable to the upcoming year. If the parties cannot agree upon future rates by the end of the Contract year, then either party may terminate the Contract for subsequent years by giving the other party written notice of termination and the termination will become effective 90 days after receipt of the written notice of termination.

D. EFFECT OF TERMINATION

1. COVERAGE

Inasmuch as the CONTRACTOR is paid on a monthly basis, the CONTRACTOR will continue providing the Covered Services required by this Contract until midnight of the last day of the calendar month in which the termination becomes effective. If an Enrollee is a patient in an inpatient hospital setting during the month in which termination becomes effective, the CONTRACTOR is responsible for the entire hospital

stay including physician charges until discharge or thirty days following termination, whichever occurs first.

2. ENROLLEE NOT LIABLE FOR DEBTS OF CONTRACTOR OR ITS SUBCONTRACTORS

If the CONTRACTOR or one of its subcontractors becomes insolvent or bankrupt, the Enrollees will not be liable for the debts of the CONTRACTOR or its subcontractor. The CONTRACTOR will include this term in all of its subcontracts.

3. INFORMATION FOR CLAIMS PAYMENT

The CONTRACTOR will promptly supply to the DEPARTMENT all information necessary for the reimbursement of any Medicaid claims not paid by the CONTRACTOR.

4. CHANGES IN ENROLLMENT PROCESS

The CONTRACTOR will be advised of anticipated changes in policies and procedures as they relate to the enrollment process and their comments will be solicited. The CONTRACTOR agrees to be bound by such changes in policies and procedures unless they are not agreeable to the CONTRACTOR, in which case the CONTRACTOR may terminate the Contract in accordance with the Contract termination provisions.

5. HEARING PRIOR TO TERMINATION

Regarding the General Provisions, Article XVII (Default, Termination, & Payment Adjustment), item 3, if the CONTRACTOR fails to meet the requirements of the Contract, the DEPARTMENT must give the CONTRACTOR a hearing prior to termination. Enrollees must be informed of the hearing and will be allowed to disenroll from the MCO without cause.

E. ASSIGNMENT

Assignment of any or all rights or obligations under this Contract without the prior written consent of the DEPARTMENT is prohibited. Sale of all or any part of the rights or obligations under this Contract will be deemed an assignment. Consent may be withheld in the DEPARTMENT's sole and absolute discretion.

ARTICLE XII - MISCELLANEOUS

A. INTEGRATION

This Contract contains the entire agreement between the parties with respect to the subject matter of this Contract. There are no representations, warranties, understandings, or agreements other than those expressly set forth herein. Previous contracts between the parties hereto and conduct between the parties which precedes the implementation of this Contract will not be used as a guide to the interpretation or enforcement of this Contract or any provision hereof.

B. ENROLLEES MAY NOT ENFORCE CONTRACT

Although this Contract relates to the provision of benefits for Enrollees and others, no Enrollee is entitled to enforce any provision of this Contract against the CONTRACTOR nor will any provision of this Contract be constructed to constitute a promise by the CONTRACTOR to any Enrollee or potential Enrollee.

C. INTERPRETATION OF LAWS AND REGULATIONS

The DEPARTMENT will be responsible for the interpretation of all federal and State laws and regulations governing or in any way affecting this Contract. When interpretations are required, the CONTRACTOR will submit written requests to the DEPARTMENT. The DEPARTMENT will retain full authority and responsibility for the administration of the Medicaid program in accordance with the requirements of Federal and State law.

D. ADOPTION OF RULES

Adoption of rules by the DEPARTMENT, subsequent to this amendment, and which govern the Medicaid program, will be automatically incorporated into this Contract upon receipt by the CONTRACTOR of written notice thereof.

ARTICLE XIII - EFFECT OF GENERAL PROVISIONS

If there is a conflict between these Special Provisions (Attachment B) or the General Provisions (Attachment A), then these Special Provisions will control.

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ATTACHMENT C - COVERED SERVICES
LIMITATIONS & EXCLUSIONS
CO-PAYMENT & CO-INSURANCE REQUIREMENTS

Covered Services are the same under both the Traditional and Non-Traditional Medicaid Plans unless otherwise indicated. Co-payments and co-insurances are listed if required. Pregnant women and children under age 18 are exempt from all co-payment and co-insurance requirements. Services related to family planning are excluded from all co-payment and co-insurance requirements. Medicaid Provider Manuals provide detailed information regarding covered services and are available to the CONTRACTOR upon request.

A. IN GENERAL

The CONTRACTOR will provide the following benefits to Enrollees in accordance with Medicaid benefits as defined in the Utah State Plan subject to the exception or limitations as noted below. The DEPARTMENT reserves the right to interpret what is in the State plan. Medicaid services can only be limited through utilization criteria based on Medical Necessity. The CONTRACTOR will provide at least the following benefits to Enrollees.

The CONTRACTOR is responsible to provide or arrange for all Medically Necessary Covered Services on an emergency basis 24 hours each day, seven days a week. The CONTRACTOR is responsible for payment for all covered Emergency Services furnished by providers that do not have arrangements with the CONTRACTOR.

B. HOSPITAL SERVICES

1. INPATIENT HOSPITAL

Services furnished in a licensed, certified hospital.

Non-Traditional Medicaid Plan excludes the following revenue codes:
430 - 439 (Occupational Therapy)
380 - 382, and 391 (Whole Blood)
390 and 399 (Autologous or self blood storage for future use)
811 - 813 (Organ Donor charges)

CO-INSURANCE
Traditional Medicaid: $[*] for non-emergency admissions.
Limited to $[*] per Enrollee per calender year.
Non-Traditional Medicaid: $[*] for each non-emergency admission per Enrollee. Counts toward total maximum co-payment and co-insurance of $[*] per Enrollee per calendar year.

2. OUTPATIENT HOSPITAL

Services provided to Enrollees at a licensed, certified hospital who are not admitted to the hospital.

CO-PAYMENT
Traditional Medicaid: $[*] co-payment per visit. Limited to one co-payment per date of service per provider. The facility fees associated with services provided in an outpatient hospital or free-standing ambulatory surgical centers are subject to $[*] co-payment per date of service per provider. Annual calendar year maximum for any combination of physician, podiatry, outpatient hospital, and surgical centers is $[*] per Enrollee.
Non-Traditional Medicaid: $[*] co-payment per visit. Limited to one co-payment per date of service per provider. The facility fees associated with services provided in an outpatient hospital or a free standing ambulatory surgical centers are subject to $[*] co-payment per date of service per provider. Counts toward total maximum co-payment and co-insurance of $[*] per Enrollee per calendar year.

3. EMERGENCY DEPARTMENT SERVICES

Emergency Services provided to Enrollees in designated hospital emergency departments.

CO-PAYMENT
Traditional Medicaid: $[*] co-payment for non-emergency use of the emergency room.
Non-Traditional Medicaid: $[*] co-payment for non-emergency use of the emergency room. Counts toward total maximum co-payment and co-insurance of $[*] per Enrollee per calendar year.

C. PHYSICIAN SERVICES

Services provided directly by licensed physicians or osteopaths, or by other licensed professionals such as physician assistants, nurse practitioners, or nurse midwives under the physician's or osteopath's supervision.

Non-Traditional Medicaid Excludes office visits in conjunction with allergy injections (CPT codes 95115 through 95134 and 95144 through 95199).

CO-PAYMENT
Traditional Medicaid: $[*] co-payment per visit. Limited to one co-payment per date of service per provider. Annual calendar year maximum is $[*] per Enrollee for any combination of physician, podiatry, outpatient hospital, freestanding emergency centers,

and surgical centers. Co-payment required for preventive services and immunizations.
Non-Traditional Medicaid: $[*] co-payment per visit. Limited to one co-payment per date of service per provider. No co-payment for preventive services and immunizations. Counts toward total maximum co-payment and co-insurance of $[*] per Enrollee per calendar year.

D. GENERAL PREVENTIVE SERVICES

The CONTRACTOR must develop or adopt practice guidelines consistent with current standards of care, as recommended by professional groups such as the American Academy of Pediatric and the U.S. Task Force on Preventive Care.

A minimum of three screening programs for prevention or early intervention (e.g. Pap Smear, diabetes, hypertension).

E. VISION CARE

Services provided by licensed ophthalmologists or licensed optometrists, and opticians within their scope of practice. Eyeglasses will be provided to eligible recipients based on medical necessity. Services include, but are not limited to, the following:

1. Eye refractions, examinations
2. Laboratory work
3. Lenses
4. Eyeglass Frames
5. Repair of Frames
6. Repair or Replacement of Lenses
7. Contact Lenses (when Medically Necessary)

Non-Traditional Medicaid Plan is limited to the following service and limitation: Eye refraction/examination is limited to one eye examination every 12 months. Annual coverage limited to $[*]. All amounts over $[*] paid by Enrollee. No coverage for eyeglasses.

F. LAB AND RADIOLOGY SERVICES

Professional and technical laboratory and X-ray services furnished by licensed and certified providers. All laboratory testing sites, including physician office labs, providing services under this Contract will have either a Clinical Laboratory Improvement Amendments (CLIA) certificate of Waiver or a certificate of registration along with a CLIA identification number.

Those laboratories with certificates of waiver will provide only the eight types of tests permitted under the terms of their waiver. Laboratories with certificates of registration

may perform a full range of laboratory tests.

G. PHYSICAL AND OCCUPATIONAL THERAPY

1. PHYSICAL THERAPY

Treatment and services provided by a licensed physical therapist. Treatment and services must be authorized by a physician and include services prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law and provided to an Enrollee by or under the direction of a qualified physical therapist. Necessary supplies and equipment will be reviewed for medical necessity and follow the criteria of the R414.12 rule.

2. OCCUPATIONAL THERAPY

Treatment of services provided by a licensed occupational therapist. Treatment and services must be authorized by a physician and include services prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law and provided to an Enrollee by or under the direction of a qualified occupational therapist. Necessary supplies and equipment will be reviewed for medical necessity and follow the criteria of the R414.12 rule.

Non-Traditional Medicaid Plan is limited by the number of services: Visits to a licensed physical therapist, licensed occupational therapist and chiropractor are limited to a combination of 16 visits per calendar year. Chiropractic services are covered under fee-for-service and are not the responsibility of the CONTRACTOR.

CO-PAYMENT
Non-Traditional Medicaid: $[*] co-payment per visit. Limited to one co-payment per date of service per provider. Counts toward total maximum co-payment and co-insurance of $[*] per Enrollee per calendar year.

H. SPEECH AND HEARING SERVICES

Services and appliances, including hearing aids and hearing aid batteries, provided by a licensed medical professional to test and treat speech defects and hearing loss.

Traditional Medicaid Plan: Coverage is limited to children up to age 21 and pregnant women.

Non-Traditional Medicaid Plan: Not covered.

I. PODIATRY SERVICES

Services provided by a licensed podiatrist.

Traditional Medicaid Plan: Full coverage is limited to children up to age 21 and pregnant women. Effective October 1, 2002, limited podiatry benefits are covered for adults.

Non-Traditional Medicaid Plan: Effective October 1, 2002, limited podiatry benefits are covered.

CO-PAYMENT
Traditional Medicaid: $[*] co-payment per visit. Limited to one co-payment per date of service per provider. Annual calendar year maximum is $[*] per Enrollee for any combination of physician, podiatry, outpatient hospital, freestanding emergency centers, and surgical centers. Co-payment required for preventive services and immunizations.
Non-Traditional Medicaid: $[*] co-payment per visit. Limited to one co-payment per date of service per provider. Counts toward total maximum co-payment and co-insurance of $[*] per Enrollee per calendar year.

J. END STAGE RENAL DISEASE - DIALYSIS

Treatment of end stage renal dialysis for kidney failure. Dialysis is to be rendered by a Medicare-certified Dialysis facility.

K. HOME HEALTH SERVICES

Home health services are defined as intermittent nursing care provided by certified nursing professionals (registered nurses, licensed practical nurses, and home health aides) in the client's home when the client is homebound or semi-homebound. Home health care must be rendered by a Medicare-certified Home Health Agency that has a surety bond.

Personal care services as defined in the DEPARTMENT's Medicaid Personal Care Provider Manual are included in this Contract. Personal care services may be provided by a State licensed home health agency.

L. HOSPICE SERVICES

Services delivered to terminally ill patients (six months life expectancy) who elect palliative versus aggressive care. Hospice care must be rendered by a Medicare-certified hospice.

M. PRIVATE DUTY NURSING

Services provided by licensed nurses for ventilator-dependent children and technology-dependent adults in their home in lieu of hospitalization if Medically Necessary, feasible, and safe to be provided in the patient's home. Requests for continuous care will be evaluated on a case by case basis and must be approved by the CONTRACTOR.

Non-Traditional Medicaid Plan: Private Duty Nursing is not a covered service.

N. MEDICAL SUPPLIES AND MEDICAL EQUIPMENT

This Covered Service includes any necessary supplies and equipment used to assist the Enrollee's medical recovery, including both durable and non-durable medical supplies and equipment, and prosthetic devices. The objective of the medical supplies program is to provide supplies for maximum reduction of physical disability and restore the Enrollee to his or her best functional level. Medical supplies may include any necessary supplies and equipment recommended by a physical or occupational therapist, but should be ordered by a physician. Durable medical equipment (DME) includes, but is not limited to, prosthetic devices and specialized wheelchairs. Durable medical equipment and supplies must be provided by a DME supplier that has a surety bond. Necessary supplies and equipment will be reviewed for medical necessity and follow the criteria of the R414.12 of the Utah Administrative Code, with the exception of criteria concerning long term care since long term care services are not covered under the Contract.

Non-Traditional Medicaid Plan excludes blood pressure monitors, and replacement of lost, damaged, or stolen durable medical equipment or prosthesis.

O. ABORTIONS AND STERILIZATIONS

These services are provided to the extent permitted by Federal and State law and must meet the documentation requirement of 42 CFR 441, Subparts E and F. These requirements must be met regardless of whether Medicaid is primary or secondary payer.

P. TREATMENT FOR SUBSTANCE ABUSE AND DEPENDENCY

Treatment will cover medical detoxification for alcohol or substance abuse conditions. Medical services including hospital services will be provided for the medical non-psychiatric aspects of the conditions of alcohol/drug abuse.

Q. ORGAN TRANSPLANTS

The following transplantations are covered for all Enrollees: Kidney, liver, cornea, bone marrow, stem cell, heart, intestine, lung, pancreas, small bowel, combination heart/lung, combination intestine/liver, combination kidney/pancreas, combination liver/kidney,

multi visceral, and combination liver/small bowel unless amended under the provisions of Attachment B, Article IV (Benefits), Section C, Subsection 2 of this Contract.

Non-Traditional Medicaid Plan is limited to kidney, liver, cornea, bone marrow, stem cell, heart, and lung transplantations.

R. OTHER OUTSIDE MEDICAL SERVICES

The CONTRACTOR, at its discretion and without compromising quality of care, may choose to provide services in Freestanding Emergency Centers, Surgical Centers and Birthing Centers.

CO-PAYMENT
Traditional Medicaid: $[*] co-payment per visit. Limited to one co-payment per date of service per provider. Annual calendar year maximum is $[*] per Enrollee for any combination of physician, podiatry, outpatient hospital, freestanding emergency centers, and surgical centers. (Co-payment does not apply to birthing centers.)
Non-Traditional Medicaid: $[*] co-payment per visit. Limited to one co-payment per date of service per provider. Counts toward total maximum co-payment and co-insurance of $[*] per Enrollee per calendar year.

S. LONG TERM CARE

The CONTRACTOR may provide long term care for Enrollees in skilled nursing facilities requiring such care as a continuum of a medical plan when the plan includes a prognosis of recovery and discharge within thirty (30) days or less. When the prognosis of an Enrollee indicates that long term care (over 30 days) will be required, the CONTRACTOR will notify the DEPARTMENT and the skilled nursing facility of the prognosis determination and will initiate disenrollment to be effective on the first day of the month following the prognosis determination. Skilled nursing care is to be rendered in a skilled nursing facility which meets federal regulations of participation.

T. TRANSPORTATION SERVICES

Ambulance (ground and air) service for medical emergencies. The CONTRACTOR is also responsible to pay for authorized emergency transportation for an illness or accident episode which, upon subsequent medical evaluation at the hospital, is determined to be psychiatric-related. The CONTRACTOR will submit its emergency transportation policy to the DEPARTMENT for review. The CONTRACTOR is not responsible for transporting an Enrollee from an acute care facility to another acute care facility for a psychiatric admission. The CONTRACTOR's scope of coverage for emergency transportation services is limited to the same scope of coverage as defined in the transportation Medicaid provider manual.

Effective September 1, 2002 the CONTRACTOR is not responsible for ambulance (ground and air) services.

U. SERVICES TO CHEC ENROLLEES

1. CHEC SERVICES

The CONTRACTOR will provide to CHEC Enrollees preventive screening services and other necessary medical care, diagnostic services, treatment, and other measures necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State Medicaid Plan. The CONTRACTOR is not responsible for home and community-based services available through Utah's Home and Community-Based waiver programs.

The CONTRACTOR will provide the full early and periodic screening, diagnosis, and treatment services to all eligible children and young adults up to age 21 in accordance with the periodicity schedule as described in the Utah CHEC Provider Manual. All children between six months and 72 months must be screened for blood lead levels.

Non-Traditional Medicaid: CHEC services are not covered. Enrollees who are 19 or 20 years of age receive the adult scope of services.

2. CHEC POLICIES AND PROCEDURES

The CONTRACTOR agrees to have written policies and procedures for conducting tracking, follow-up, and outreach to ensure compliance with the CHEC periodicity schedules. These policies and procedures will emphasize outreach and compliance monitoring for children and young adults, taking into account the multi-lingual, multi-cultural nature as well as other unique characteristics of the CHEC Enrollees.

V. FAMILY PLANNING SERVICES

This service includes disseminating information, counseling, and treatments relating to family planning services. All services must be provided by or authorized by a physician, certified nurse midwife, or nurse practitioner. All services must be provided in concert with Utah law.

Birth control services include information and instructions related to the following:

1. Birth control pills;
2. Norplant;

3. Depo Provera;
4. IUDs;
5. Barrier methods including diaphragms, male and female condoms, and cervical caps;
6. Vasectomy or tubal ligations; and
7. Office calls, examinations or counseling related to contraceptive devices.

Non-Traditional Medicaid: Norplant is not a covered service.

W. HIGH-RISK PRENATAL SERVICES

1. IN GENERAL - ENSURE SERVICE ARE APPROPRIATE AND COORDINATED

The CONTRACTOR must ensure that high risk pregnant Enrollees receive an appropriate level of quality perinatal care that is coordinated, comprehensive and continuous either by direct service or referral to an appropriate provider or facility. In the determination of the provider and facility to which a high risk prenatal Enrollee will be referred, care must be taken to ensure that the provider and facility both have the appropriate training, expertise and capability to deliver the care needed by the Enrollee and her fetus/infant. Although many complications in perinatal health cannot be anticipated, most can be identified early in pregnancy. Ideally, preconceptional counseling and planned pregnancy are the best ways to assure successful pregnancy outcome, but this is often not possible. Provision of routine preconceptional counseling must be made available to those women who have conditions identified as impacting pregnancy outcome, i.e., diabetes mellitus, medications which may result in fetal anomalies or poor pregnancy outcome, or previous severe anomalous fetus/infant, among others.

2. RISK ASSESSMENT

a. CRITERIA

Enrollees who are pregnant should be risk assessed for medical and psychosocial conditions which may contribute to a poor birth outcome at their first prenatal visit, preferably in the first trimester. The patient who is determined not to be at high risk should be evaluated for change in risk status throughout her pregnancy. There are a number of complex systems to determine how to assess the risk of pregnancies. The DEPARTMENT has developed a risk assessment tool available through the Division of Community and Family Health Services which is available upon request.

b. RECOMMENDED PRENATAL SCREENING

The DEPARTMENT recommends prenatal screening of every woman for

hepatitis B surface antigen (HBsAg) to identify all those at high risk for transmitting the virus to their newborns. When a woman is found to be HBsAg-positive, the CONTRACTOR will provide HBIG and HB vaccine at birth. Initial treatments should be given during the first 12 hours of life.

c. CLASSIFICATION

Upon identification of pregnancy or the development of a risk factor, each patient should be assigned a classification as outlined below.

1) Group I

Group I patients have no significant risk factors. They may receive obstetrical care by an obstetrician/gynecologist (OB/GYN), family practitioner or certified nurse midwife.

2) Group II

Group II patients have the following risk factors, and require consultation (consultation may be either by telephone or in person, as appropriate) with an OB/GYN:

i. pregnancy beyond 42 weeks
ii. preterm labor in the current pregnancy less than 34 weeks
iii. fetal malpresentation at 37 weeks gestation and beyond*
iv. oxytocin or antepartum prostaglandin use is contemplated*
v. arrest of dilatation in labor, or arrest of descent in labor*
vi. bleeding in labor, beyond bloody show*
vii. abnormal fetal heart rate pattern potentially requiring specific intervention*
viii. chorioamnionitis*
ix. preeclampsia
x. VBAC*

*Criteria do not apply if family physician has cesarean privileges.

3) Group III

Group III patients have the following risk factors, and require consultation by a Maternal Fetal Medicine (MFM) specialist (board certified perinatologist)

i. intrauterine growth restriction prior to 37 weeks
ii. patient at increased risk for fetal anomaly (including teratogen exposure)
iii. patient has known fetal anomaly
iv. preterm delivery (<36 weeks) in a prior pregnancy
v. abnormal serum screening
vi. previous child with congenital anomaly
vii. antibody sensitization

- viii. anemia, excluding iron deficiency
- ix. significant concurrent medical illness
- x. spontaneous premature rupture of the membranes, not in labor (<34 weeks)
- xi. history of thromboembolic disease
- xii. thromboembolic disease in current pregnancy
- xiii. habitual pregnancy loss (3 or more consecutive losses)
- xiv. two or more previous stillbirths or neonatal deaths

4) Group IV

Group IV patients have the following risk factors, and require total obstetric care by an OB/GYN, or co-management with an OB/GYN or MFM

- i. any significant medical complication, including patients with insulin dependent diabetes millitus, chronic hypertension requiring medication, maternal neoplastic disease
- ii. twins
- iii. known or suspected cervical incompetence
- iv. placenta previa beyond 28 week gestation
- v. severe preeclampsia

5) Group V

Group V patients have the following risk factors, and require total obstetric care by a MFM (exceptions may be made by a regional MFM specialist, on a case-by-case basis, after MFM consultation)

- i. triplets and above
- ii. patient has an organ transplant (except cornea)
- iii. diabetes mellitus with severe renal impairment
- iv. cardiac disease, not functional class I, including all pulmonary hypertension
- v. twin-twin transfusion syndrome
- vi. patient requires fetal surgical procedure

3. PRENATAL INITIATIVE PROGRAM

Prenatal services provided directly or through agreements with appropriate providers includes those services covered under Medicaid's Prenatal Initiative Program which includes the following enhanced services for pregnant women:

- a. perinatal care coordination
- b. prenatal and postnatal home visits

c. group prenatal and postnatal education
d. nutritional assessment and counseling
e. prenatal and postnatal psychosocial counseling

Psychosocial counseling is a service designed to benefit the pregnant client by helping her cope with the stress that may accompany her pregnancy. Enabling her to manage this stress improves the likelihood that she will have a healthy pregnancy. This counseling is intended to be short term and directly related to the pregnancy. However, pregnant women who are also suffering from a serious emotional or mental illness should be referred to an appropriate mental health care provider.

X. SERVICES FOR CHILDREN WITH SPECIAL NEEDS

1. IN GENERAL

In addition to primary care, children with chronic illnesses and disabilities need specialized care provided by trained experienced professionals. Since early diagnosis and intervention will prevent costly complications later on, the specialized care must be provided in a timely manner. The specialized care must comprehensively address all areas of need to be most effective and must be coordinated with primary care and other services to be most efficient. The children's families must be involved in the planning and delivery of the care for it to be acceptable and successful.

2. SERVICES REQUIRING TIMELY ACCESS

All children with special health care needs must have timely access to the following services:

a. Comprehensive evaluation for the condition.

b. Pediatric subspecialty consultation and care appropriate to the condition.

c. Rehabilitative services provided by professionals with pediatric training in areas such as physical therapy, occupational therapy and speech therapy.

d. Durable medical equipment appropriate for the condition.

e. Care coordination for linkage to early intervention, special education and family support services and for tracking progress.

In addition, children with the conditions marked by * below must have timely access to coordinated multispecialty clinics, when Medically Necessary, for their disorder.

3. DEFINITION OF CHILDREN WITH SPECIAL HEALTH CARE NEEDS

The definition of children with special health needs includes, but is not limited to, the following conditions:

a. Nervous System Defects such as
   Spina Bifida*
   Sacral Agenesis*
   Hydrocephalus

b. Craniofacial Defects such as
   Cleft Lip and Palate*
   Treacher - Collins Syndrome

c. Complex Skeletal Defects such as
   Arthrogryposis*
   Osteogenesis Imperfecta*
   Phocomelia*

d. Inborn Metabolic Disorders such as
   Phenylketonuria*
   Galactosemia*

e. Neuromotor Disabilities such as
   Cerebral palsy*
   Muscular Dystrophy*
   Complex Seizure Disorders

f. Congenital Heart Defects

g. Genetic Disorders such as
   Chromosome Disorders
   Genetic Disorders

h. Chronic Illnesses such as
   Cystic Fibrosis
   Hemophilia
   Rheumatoid Arthritis
   Bronchopulmonary Dysplasia
   Cancer
   Diabetes
   Nephritis
   Immune Disorders

i. Developmental Disabilities with multiple or global delays in development such as Down Syndrome or other conditions associated with mental retardation.

The CONTRACTOR agrees to cover all Medically Necessary services for children with special health care needs such as the ones listed above. The CONTRACTOR further agrees to cooperate with the DEPARTMENT's quality assurance monitoring for this population by providing requested information.

Y. MEDICAL AND SURGICAL SERVICES OF A DENTIST

1. WHO MAY PROVIDE SERVICES

Under Utah law, medical and surgical services of a dentist may be provided by either a physician or a doctor of dental medicine or dental surgery.

2. UNIVERSE OF COVERED SERVICES

Medical and surgical services that under Utah law may be provided by a physician or a doctor of dental medicine or dental surgery, are covered under the Contract.

3. SERVICES SPECIFICALLY COVERED

The CONTRACTOR is responsible for palliative care and pain relief for severe mouth or tooth pain in an emergency room. If the emergency room physician determines that it is not an emergency and the client requires services at a lesser level, the provider should refer the client to a dentist for treatment. If the dental-related problem is serious enough for the client to be admitted to the hospital, the CONTRACTOR is responsible for coverage of the inpatient hospital stay. The CONTRACTOR is responsible for authorized/approved medical services provided by oral surgeons consistent with injury, accident, or disease (excluding dental decay and periodontal disease) including, but not limited to, removal of tumors in the mouth, setting and wiring a fractured jaw. Also covered are injuries to sound natural teeth and associated bone and tissue resulting from accidents including services by dentists performed in facilities other than the emergency room or hospital.

4. DENTAL SERVICES NOT COVERED

The CONTRACTOR is not responsible for routine dental services such as fillings, extractions, treatment of abscess or infection, orthodontics, and pain relief when provided by a dentist in the office or in an outpatient setting such as a surgical center or scheduled same day surgery in a hospital including the surgical facilities charges.

Z. DIABETES EDUCATION

The CONTRACTOR shall provide diabetes self-management education from a Utah certified or American Diabetes Association recognized program when an Enrollee:

1. has recently been diagnosed with diabetes, or

2. is determined by the health care professional to have experienced a significant change in symptoms, progression of the disease or health condition that warrants changes in the Enrollee's self-management plan, or

3. is determined by the health care professional to require re-education or refresher training.

AA. HIV PREVENTION

The CONTRACTOR shall have in place the following:

1. GENERAL PROGRAM

The CONTRACTOR must have educational methods for promoting HIV prevention to Enrollees. HIV prevention information, both primary (targeted to uninfected Enrollees), as well as secondary (targeted to those Enrollees with HIV) should must be culturally and linguistically appropriate. All Enrollees should be informed of the availability of both in-plan HIV counseling and testing services, as well as those available from Utah State-operated programs.

2. FOCUSED PROGRAM FOR WOMEN

Special attention should be paid identifying HIV+ women and engaging them in routine care in order to promote treatment including, but not limited to, antiretroviral therapy during pregnancy.

SUMMARY OF CO-PAYMENT AND
CO-INSURANCE REQUIREMENTS

Pregnant women and children under age 18 are exempt from all co-payment and co-insurance requirements. Services related to family planning are excluded from all co-payment and co-insurance requirements.

A. TRADITIONAL MEDICAID PLAN

1. Inpatient hospital: Each Enrollee must pay a $[*] co-insurance for non-emergency inpatient hospital admissions. The maximum co-payment per Enrollee per calendar year is $[*] for non-emergency inpatient hospital admissions.

2. Emergency Department: Each enrollee must pay a $[*] co-payment for non-emergency use of the emergency room.

3. Physician, osteopath, podiatrist, outpatient hospital, freestanding emergency centers, and surgical centers: Each Enrollee must pay a $[*] co-payment per provider per day. The maximum co-payment per Enrollee per calendar year is $[*] for any combination of the services provided by the above providers.

4. Prescription Drugs: Each Enrollee must pay a co-payment of $[*] per prescription. The maximum co-payment is $[*] per Enrollee per month.*

There is no overall out-of-pocket maximum for the above services.

B. NON-TRADITIONAL MEDICAID PLAN

1. Inpatient hospital: Each Enrollee must pay a $[*] co-insurance for each non-emergency inpatient hospital admissions.

2. Emergency Department: Each enrollee must pay a $[*] co-payment for non-emergency use of the emergency room.

3. Physician, osteopath, podiatrist, physical therapist, occupational therapist, chiropractor*, freestanding emergency centers, surgical centers: Each Enrollee must pay a $[*] co-payment per provider per day.

4. Prescription Drugs: Each Enrollee must pay a co-payment of $[*] per prescription.*

The out-of-pocket maximum for each Enrollee is $[*] for any combination of the above co-payments and co-insurance.

* Pharmacy services and chiropractic services are not the responsibility of the CONTRACTOR.

PROVIDER NAME: ______________________

ATTACHMENT E
TABLE 1 PAGE 1 OF 15
MEDICAID ENROLLMENT

SERVICE REPORTING PERIOD: BEGINNING ________ ENDING ________

PAYMENT DATES: BEGINNING ________ ENDING ________

Effective Date: July 1, 2002

		TRADITIONAL MEDICAID RATE CELLS											NON-TRADITIONAL MEDICAID RATE CELLS				
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
LINE NO	MONTH	AGE 0-12 Mos.	TANF MALE 1-18	TANF FEMALE 1-18	AGED	DIS-ABLED MALE	DIS-ABLED FEMALE	MED NEEDY CHILD 1-18	NON TANF PREGNANT FEMALE	BREAST/ CERVICAL CANCER	RESTRIC-TION PROGRAM 0-18	AIDS	TANF MALE 19 & OVER	TANF FEMALE 19 & OVER	MED NEEDY 19 & OVER	RESTRIC-TION PROGRAM 19 & OVER	MEDICAID TOTAL (SUM OF COLS)
1	JULY																0
2	AUGUST																0
3	SEPTEMBER																0
4	OCTOBER																0
5	NOVEMBER																0
6	DECEMBER																0
7	JANUARY																0
8	FEBRUARY																0
9	MARCH																0
10	APRIL																0
11	MAY																0
12	JUNE																0
13	TOTAL	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

PROVIDER NAME: ____ ATTACHMENT E

TABLE 2 PAGE 1 OF 2

SERVICE REPORTING PERIOD: BEGINNING _________ ENDING __________

REVENUES AND COST

PAYMENT DATES: BEGINNING _________ ENDING __________

MEDICAID (CAPITATED ONLY, NO FEE FOR SERVICE)

			TRADITIONAL MEDICAID RATE CELLS											NON-TRADITIONAL MEDICAID RATE CELLS				
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19
LINE NO	DESCRIPTION	TOTAL UTAH OPERATIONS (INCLUDING ALL MEDICAID)	AGE 0-12 MOS.	TANF MALE 1-18	TANF FEMALE 1-18	AGED	DISABLED MALE	DISABLED FEMALE	MED NEEDY CHILD 1-18	NON TANF PREGNANT FEMALE	BREAST/ CERVICAL CANCER	RESTRICTION PROGRAM 0-18	AIDS	TANF MALE 19 & OVER	TANF FEMALE 19 & OVER	MED NEEDY 19 & OVER	RESTRICTION PROGRAM 19 & OVER	MEDICAID TOTAL (SUM OF COLS 4 THRU 16
	REVENUES								ROUND TO THE NEAREST DOLLAR									
1	PREMIUMS																	$0
2	DELIVERY FEES (CHILD BIRTHS)																	$0
3	REINSURANCE																	$0
4	STOP LOSS																	$0
5	TFL COLLECTIONS - MEDICARE																	$0
6	TFL COLLECTIONS - OTHER																	$0
7	OTHER (SPECIFY)																	$0
8	OTHER (SPECIFY)																	$0
9	TOTAL REVENUES	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	MEDICAL COSTS								ROUND TO THE NEAREST DOLLAR									
10	INPATIENT HOSPITAL SERVICES																	$0
11	OUTPATIENT HOSPITAL SERVICES																	$0
12	EMERGENCY DEPARTMENT SERVICES																	$0
13	PRIMARY CARE PHYSICIAN SERVICES																	$0
14	SPECIALTY CARE PHYSICIAN SERVICES																	$0
15	ADULT SCREENING SERVICES																	$0
16	VISION CARE - OPTOMETRIC SERVICES																	$0
17	VISION CARE - OPTICAL SERVICES																	$0
18	LABORATORY (PATHOLOGY) SERVICES																	$0
19	RADIOLOGY SERVICES																	$0
20	PHYSICAL AND OCCUPATIONAL THERAPY																	$0
21	SPEECH AND HEARING SERVICES																	$0
22	PODIATRY SERVICES																	$0
23	END STAGE RENAL DISEASE (ESRD) SERVICES - DIALYSIS																	$0
24	HOME HEALTH SERVICES																	$0
25	HOSPICE SERVICES																	$0
26	PRIVATE DUTY NURSING																	$0
27	MEDICAL SUPPLIES AND MEDICAL EQUIPMENT																	$0
28	ABORTIONS																	$0
29	STERILIZATIONS																	$0
30	DETOXIFICATION																	$0
31	ORGAN TRANSPLANTS																	$0
32	OTHER OUTSIDE MEDICAL SERVICES																	$0
33	LONG TERM CARE																	$0
34	TRANSPORTATION SERVICES																	$0
35	ACCRUED COSTS																	$0
36	OTHER (SPECIFY)																	$0
37	OTHER (SPECIFY)																	$0
38	TOTAL MEDICAL COST	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0

1	2	3	4	5	6	7	8	9	10	11	12	13	14
			MEDICAID (CAPITATED ONLY, NO FEE FOR SERVICE)										
			TRADITIONAL MEDICAID RATE CELLS										
LINE NO	DESCRIPTION	TOTAL UTAH OPERATIONS (INCLUDING ALL MEDICAID)	AGE 0-12 Mos.	TANF MALE 1-18	TANF FEMALE 1-18	AGED	DISABLED MALE	DISABLED FEMALE	MED NEEDY CHILD 1-18	NON TANF PREGNANT FEMALE	BREAST/ CERVICAL CANCER	RESTRICTION PROGRAM 0-18	AIDS
	ADMINISTRATIVE COSTS		ROUND TO THE NEAREST DOLLAR										
39	ADMINISTRATION - ADVERTISING												
40	HOME OFFICE INDIRECT COST ALLOCATIONS												
41	UTILIZATION												
42	ADMINISTRATION - OTHER												
43	TOTAL ADMINISTRATIVE COSTS	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
44	TOTAL COSTS [MED & ADMIN]	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
45	NET INCOME [GAIN OR (LOSS)]	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
46	ENROLLEE MONTHS		0	0	0	0	0	0	0	0	0	0	0
47	MEDICAL COST @ ENROLLEE MO												
48	ADMIN COST @ ENROLLEE MO												
49	TOTAL COST @ ENROLLEE MO												
	OTHER DATA												
50	TPL SAVINGS - COST AVOIDANCE**												
51	DUPLICATE PREMIUMS***												
52	NUMBER OF DELIVERIES****												
53	FAMILY PLANNING SERVICES												
54	REINSURANCE PREMIUMS RECEIVED												
55	REINSURANCE PREMIUMS PAID												
56	ADMINISTRATIVE REVENUE RETAINED BY THE CONTRACTOR												

1	2	15	16	17	18	19
		MEDICAID (CAPITATED ONLY, NO FEE FOR SERVICE)				
		NON-TRADITIONAL MEDICAID RATE CELLS				
LINE NO	DESCRIPTION	TANF MALE 19 & OVER	TANF FEMALE 19 & OVER	MED NEEDY 19 & OVER	RESTRICTION PROGRAM 19 & OVER	MEDICAID TOTAL (SUM OF COLS 4 THRU 16)
	ADMINISTRATIVE COSTS	ROUND TO THE NEAREST DOLLAR				
39	ADMINISTRATION - ADVERTISING					$0
40	HOME OFFICE INDIRECT COST ALLOCATIONS					$0
41	UTILIZATION					$0
42	ADMINISTRATION - OTHER					$0
43	TOTAL ADMINISTRATIVE COSTS	$0	$0	$0	$0	$0
44	TOTAL COSTS [MED & ADMIN]	$0	$0	$0	$0	$0
45	NET INCOME [GAIN OR (LOSS)]	$0	$0	$0	$0	$0
46	ENROLLEE MONTHS	0	0	0	0	0
47	MEDICAL COST @ ENROLLEE MO					$0
48	ADMIN COST @ ENROLLEE MO					$0
49	TOTAL COST @ ENROLLEE MO					$0

OTHER DATA

No.	Item	Amount
50	TPL SAVINGS - COST AVOIDANCE**	$0
51	DUPLICATE PREMIUMS***	$0
52	NUMBER OF DELIVERIES****	$0
53	FAMILY PLANNING SERVICES	$0
54	REINSURANCE PREMIUMS RECEIVED	$0
55	REINSURANCE PREMIUMS PAID	$0
56	ADMINISTRATIVE REVENUE RETAINED BY THE CONTRACTOR	$0

** COST OF SERVICES PROVIDED TO HMO CLIENTS, NOT PAID FOR BY HMO, E.G. "AVOIDED", BECAUSE OTHER INSURANCE PAID FOR IT.

*** CASH AMOUNT RETURNED TO MEDICAID BY HMO BECAUSE HMO CLIENT WAS COVERED IN THE SAME HMO BY ANOTHER CARRIER.

**** NUMBER OF CHILDREN DELIVERED. THIS NUMBER TIMES RATES SHOULD EQUAL DELIVERY REVENUE.

In this Medicaid portion, include only costs for Medicaid clients under the capitation agreement - exclude revenue, costs & TPL categories per this form that do not apply to your organization or contract.

MEDICAL SERVICES REVENUE AND COST DEFINITIONS FOR TABLE 2

REVENUES (Report all revenues received or receivable at the end-of-period date on the form)

1. Premiums

   Report premium payments received or receivable from the DEPARTMENT.

2. Delivery Fees

   Report the delivery fee received or receivable from the DEPARTMENT.

3. Reinsurance

   Report the reinsurance payments received or receivable from a reinsurance carrier other than the DEPARTMENT.

4. Stop Loss

   Report stop loss payments received or receivable from the DEPARTMENT.

5. TPL Collections - Medicare

   Report all third party collections received from Medicare.

6. TPL Collections - Other

   Report all third party collections received other than Medicare collections. (Report TPL savings because of cost avoidance as a memo amount on line 48).

7. Other (specify)

8. Other (specify)

   For lines seven and eight: Report all other revenue not included in lines one through six. (There may not be any amount to report; however, this line can be used to report revenue from total Utah operations that do not fit lines one through six.)

9. TOTAL REVENUES

   Total lines one through eight.

NOTE: Duplicate premiums are not considered a cost or revenue as they are collected by the CONTRACTOR and paid to the DEPARTMENT. Therefore, the payment to the DEPARTMENT would reduce or offset the revenue recorded when the duplicate premium was received. However, line 49 has been established for reporting duplicate premiums as a memo amount.

MEDICAL COSTS: Report all costs accrued as of the ending date on the form. In the first data column (column 3), report all costs for Utah operations per the general ledger. In the 15 Medicaid data columns (columns 4 through 18), report only costs for Medicaid Enrollees.

10. Inpatient Hospital Services

Costs incurred in providing inpatient hospital services to Enrollees confined to a hospital.

11. Outpatient Hospital Services

Costs incurred in providing outpatient hospital services to Enrollees, not including services provided in the emergency department.

12. Emergency Department Services

Costs incurred in providing outpatient hospital emergency room services to Enrollees.

13. Primary Care Physician Services (Including EPSDT Services, Prenatal Care, and Family Planning Services)

All costs incurred for Enrollees as a result of providing primary care physician, osteopath, physician assistant, nurse practitioner, and nurse midwife services, including payroll expenses, any capitation and/or contract payments, fee-for-service payments, fringe benefits, travel and office supplies.

14. Specialty Care Physician Services (Including EPSDT Services, Prenatal Care, and Family Planning Services)

All costs incurred as a result of providing specialty care physician, osteopath, physician assistant, nurse practitioner, and nurse midwife services to Enrollees, including payroll expenses, any capitation and/or contract payments, fee-for-service payments, fringe benefits, travel and office supplies.

15. Adult Screening Services

Expenses associated with providing screening services to Enrollees.

16. Vision Care - Optometric Services

Included are payroll costs, any capitation and/or contract payments, and fee-for-service payments for services and procedures performed by an optometrist and other non-payroll expenses directly related to providing optometric services for Enrollees.

17. Vision Care - Optical Services

Included are payroll costs, any capitation and/or contract payments and fee-for-service payments for services and procedures performed by an optician and other supportive staff, cost of eyeglass frames and lenses and other non-payroll expenses directly related to providing optical services for Enrollees.

18. Laboratory (Pathology) Services

Costs incurred as a result of providing pathological tests or services to Enrollees including payroll

expenses, any capitation and/or contract payments, fee-for-service payments and other expenses directly related to in-house laboratory services. Excluded are costs associated with a hospital visit.

19. Radiology Services

Cost incurred in providing x-ray services to Enrollees, including x-ray payroll expenses, any capitation and/or contract payments, fee-for-service payments, and occupancy overhead costs. Excluded are costs associated with a hospital visit.

20. Physical and Occupational Therapy

Included are payroll costs, any capitation and/or contract payments, fee-for-service costs, and other non-payroll expenditures directly related to providing physical and occupational therapy services.

21. Speech and Hearing Services

Payroll costs, any capitation and/or contract payments, fee-for-service payments, and non-payroll costs directly related to providing speech and hearing services for Enrollees.

22. Podiatry Services

Salary expenses or outside claims, capitation and/or contract payments, fee-for-service payments, and non-payroll costs directly related to providing services rendered by a podiatrist to Enrollees.

23. End Stage Renal Disease (ESRD) Services - Dialysis

Costs incurred in providing renal dialysis (ESRD) services to Enrollees.

24. Home Health Services

Included are payroll costs, any capitation and/or contract payments, fee-for-service payments, and other non-payroll expenses directly related to providing home health services for Enrollees.

25. Hospice Services

Expenses related to hospice care for Enrollees including home care, general inpatient care for Enrollees suffering terminal illness and inpatient respite care for caregivers of Enrollees suffering terminal illness.

26. Private Duty Nursing

Expenses associated with private duty nursing for Enrollees.

27. Medical Supplies and Medical Equipment

This cost center contains fee-for-service cost for outside acquisition of medical requisites, special appliances as prescribed by the CONTRACTOR to Enrollees.

28. Abortions

Medical and hospital costs incurred in providing abortions for Enrollees.

29. Sterilizations

Medical and hospital costs incurred in providing sterilizations for Enrollees.

30. Detoxification

Medical and hospital costs incurred in providing treatment for substance abuse and dependency (detoxification) for Enrollees.

31. Organ Transplants

Medical and hospital costs incurred in providing transplants for Enrollees.

32. Other Outside Medical Services

The costs for specialized testing and outpatient surgical centers for Enrollees ordered by the CONTRACTOR.

33. Long Term Care

Costs incurred in providing long-term care for Enrollees required under Attachment C.

34. Transportation Services

Costs incurred in providing ambulance (ground and air) services for Enrollees.

35. Accrued Costs

Costs Incurred for services rendered to Enrollees but not yet billed.

36/37 Other

Report costs not otherwise reported.

38. TOTAL MEDICAL COSTS

Total lines 10 through 37.

ADMINISTRATIVE COSTS

Report payroll costs, any capitation and/or contract payments, non-payroll costs and occupancy overhead costs for accounting services, claims processing services, health plan services, data processing services, purchasing, personnel, Medicaid marketing and regional administration.

Report the administration cost under four categories - advertising, home office indirect cost allocation, utilization and all other administrative costs. If there are no advertising costs or indirect home office cost allocations, report a zero amount in the applicable lines.

39. Administration - Advertising

40. Home Office Indirect Cost Allocations

41. Utilization

Payroll cost and any capitation and/or contract payments for utilization staff and other non-payroll costs directly associated with controlling and monitoring outside physician referral and hospital admission and discharges of Enrollees.

42. Administration - Other

43. TOTAL ADMINISTRATIVE COSTS

Total lines 39 through 42.

44. TOTAL COSTS (MEDICAL AND ADMINISTRATIVE)

Total lines 38 and 43.

45. NET INCOME (GAIN OR LOSS)

Line 9 minus line 44.

46. ENROLLEE MONTHS

Total Enrollee months for period of time being reported.

47. MEDICAL COSTS PER ENROLLEE MONTH

Line 38 divided by line 46.

48. ADMINISTRATIVE COSTS PER ENROLLEE MONTH

Line 43 divided by line 46.

49. TOTAL COSTS PER ENROLLEE MONTH

Line 44 divided by line 46.

OTHER DATA

50. TPL Savings - Cost Avoidance

51. Duplicate Premiums

Include all premiums received for Enrollees from all sources other than Medicaid.

52. Number of Deliveries

Total number of Enrollee deliveries when the delivery occurred at 24 weeks or later.

53. Family Planning Services

Include costs associated with family planning services as defined in Attachment C (Covered Services, Section V, Family Planning Services).

54. Reinsurance Premiums Received

Include the reinsurance premiums received or receivable that are not counted as revenue.

55. Reinsurance Premiums Paid

Include reinsurance premiums paid to a reinsurance carrier other than the DEPARTMENT.

56. Administrative Revenue Retained by the CONTRACTOR

Include the administrative revenue retained by the CONTRACTOR from the reinsurance premiums received or receivable.

PROVIDER NAME: ____________________ ATTACHMENT E

SERVICE REPORTING PERIOD: BEGINNING ________ ENDING ________ TABLE 3 PAGE 1 OF 1

PAYMENT DATES: BEGINNING ________ ENDING ________ UTILIZATION

EFFECTIVE DATE: JULY 1, 2002

MEDICAID (CAPITATED ONLY, NO FEE FOR SERVICE)

TRADITIONAL MEDICAID RATE CELLS

1	2	3	4	5	6	7	8	9	10	11	12	13
LINE NO	SERVICE DESCRIPTION (REFER TO THE UNIT OF SERVICE DEFINITIONS IN THE INSTRUCTIONS)	AGE 0-12 Mos.	TANF MALE 1-18	TANF FEMALE 1-18	AGED	DISABLED MALE	DISABLED FEMALE	MED NEEDY CHILD 1-18	NON TANF PREGNANT FEMALE	BREAST/ CERVICAL CANCER	RESTRICTION PROGRAM 0-18	AIDS
1	HOSPITAL SERVICES - GENERAL DAYS											
2	HOSPITAL SERVICES - DISCHARGES											
3	HOSPITAL SERVICES - OUTPATIENT VISITS											
4	EMERGENCY DEPARTMENT VISITS											
5	PRIMARY CARE PHYSICIAN SERVICES											
6	SPECIALTY CARE PHYSICIAN SERVICES											
7	ADULT SCREENING SERVICES											
8	VISION CARE - OPTOMETRIC SERVICES											
9	VISION CARE - OPTICAL SERVICES											
10	LABORATORY (PATHOLOGY) PROCEDURES											
11	RADIOLOGY PROCEDURES											
12	PHYSICAL AND OCCUPATIONAL THERAPY SERVICES											
13	SPEECH AND HEARING SERVICES											
14	PODIATRY SERVICES											
15	RENAL DISEASE (ESRD) SERVICES - DIALYSIS											
16	HOME HEALTH SERVICES											
17	HOSPICE DAYS											
18	PRIVATE DUTY NURSING SERVICES											
19	MEDICAL SUPPLIES AND MEDICAL EQUIPMENT											
20	ABORTIONS PROCEDURES											
21	STERILIZATION PROCEDURES											
22	DETOXIFICATION DAYS											
23	ORGAN TRANSPLANTS											
24	OTHER OUTSIDE MEDICAL SERVICES											
25	LONG TERM CARE FACILITY DAYS											
26	TRANSPORTATION TRIPS											
27	OTHER (SPECIFY)											

NON-TRADITIONAL MEDICAID RATE CELLS

1	2	14	15	16	17	18
LINE NO	SERVICE DESCRIPTION (REFER TO THE UNIT OF SERVICE DEFINITIONS IN THE INSTRUCTIONS)	TANF MALE 19 & OVER	TANF FEMALE 19 & OVER	MED NEEDY 19 & OVER	RESTRICTION PROGRAM 19 & OVER	MEDICAID TOTAL (SUM OF COLS) 3 THRU 15
1	HOSPITAL SERVICES - GENERAL DAYS					
2	HOSPITAL SERVICES - DISCHARGES					
3	HOSPITAL SERVICES - OUTPATIENT VISITS					
4	EMERGENCY DEPARTMENT VISITS					
5	PRIMARY CARE PHYSICIAN SERVICES					
6	SPECIALTY CARE PHYSICIAN SERVICES					
7	ADULT SCREENING SERVICES					
8	VISION CARE - OPTOMETRIC SERVICES					
9	VISION CARE - OPTICAL SERVICES					
10	LABORATORY (PATHOLOGY) PROCEDURES					
11	RADIOLOGY PROCEDURES					
12	PHYSICAL AND OCCUPATIONAL THERAPY SERVICES					
13	SPEECH AND HEARING SERVICES					
14	PODIATRY SERVICES					
15	RENAL DISEASE (ESRD) SERVICES - DIALYSIS					
16	HOME HEALTH SERVICES					
17	HOSPICE DAYS					
18	PRIVATE DUTY NURSING SERVICES					
19	MEDICAL SUPPLIES AND MEDICAL EQUIPMENT					
20	ABORTIONS PROCEDURES					
21	STERILIZATION PROCEDURES					
22	DETOXIFICATION DAYS					
23	ORGAN TRANSPLANTS					
24	OTHER OUTSIDE MEDICAL SERVICES					
25	LONG TERM CARE FACILITY DAYS					
26	TRANSPORTATION TRIPS					
27	OTHER (SPECIFY)					

MEDICAL SERVICES UTILIZATION DEFINITIONS FOR TABLE 3

MEDICAL SERVICES

1. Hospital Services - General Days

   Record total number of inpatient hospital days associated with inpatient medical care.

2. Hospital Services - Discharges

   Record total number of inpatient hospital discharges.

3. Hospital Services - Outpatient Visits

   Record total number of outpatient visits.

4. Emergency Department Visits

   Record total number of emergency room visits

5. Primary Care Physician Services

   Number of services and procedures defined by CPT-4 codes provided by primary care physicians or licensed physician extenders or assistants under direct supervision of a physician inclusive of all services except radiology, laboratory and injections/immunizations which should be reported in their appropriate section. The reporting of data under this category includes both outpatient and inpatient services.

6. Specialty Care Physician Services

   Number of services and procedures defined by CPT-4 codes provided by specialty care physicians or licensed physician extenders or assistants under direct supervision of a physician inclusive of all services except radiology, laboratory and injections/immunizations which should be reported in their appropriate section. The reporting of data under this category includes both outpatient and inpatient services.

7. Adult Screening Services

   Number of adult screenings performed.

8. Vision Care - Optometric Services

   Number of optometric services and procedures performed by an optometrist.

9. Vision Care - Optical Services

   Number of eye glasses and contact lenses dispensed.

10. Laboratory (Pathology) Procedures

Number of procedures defined by CPT-4 Codes under the Pathology and Laboratory section. Excluded are services performed in conjunction with a hospital outpatient or emergency department visit.

11. Radiology Procedures

Number of procedures defined by CPT-4 Codes under the Radiology section. Excluded are services performed in conjunction with a hospital outpatient or emergency department visit.

12. Physical and Occupational Therapy Services

Physical therapy refers to physical and occupational therapy services and procedures performed by a physician or physical therapist.

13. Speech and Hearing Services

Number of services and procedures.

14. Podiatry Services

Number of services and procedures.

15. End Stage Renal Disease (ESRD) Services - Dialysis

Number of ESRD procedures provided upon referral.

16. Home Health Services

Number of home health visits, such as skilled nursing, home health aide, and personal care aide visits.

17. Hospice Days

Number of days hospice care is provided, including respite care.

18. Private Duty Nursing Services

Hours of skilled care delivered.

19. Medical Supplies and Medical Equipment

Durable medical equipment such as wheelchairs, hearing aids, etc., and nondurable supplies such as oxygen etc.

20. Abortion Procedures

Number of procedures performed.

21. Sterilization Procedures

Number of procedures performed.

22. Detoxification Days

Days of inpatient detoxification.

23. Organ Transplants

Number of transplants.

24. Other Outside Medical Services

Specialized testing and outpatient surgical services ordered by IHC.

25. Long Term Care Facility Days

Total days associated with long-term care.

26. Transportation Trips

Number of ambulance trips.

27. Other (specify)

MEDICAID MALPRACTICE INFORMATION

PROVIDER NAME: ____

SERVICE REPORTING PERIOD: BEGINNING ________ ENDING __________

ORGANIZATIONS NAMED IN THE MALPRACTICE CLAIM:
CLAIM NUMBER 1 ____
CLAIM NUMBER 2 ____
CLAIM NUMBER 3 ____

MEDICAL PROFESSIONALS SPECIFIED:
CLAIM NUMBER 1 ____
CLAIM NUMBER 2 ____
CLAIM NUMBER 3 ____

LOCATIONS WHERE CLAIMS ORIGINATED:
CLAIM NUMBER 1 ____
CLAIM NUMBER 2 ____
CLAIM NUMBER 3 ____

MEDICAID CLIENT IDENTIFICATION:
CLAIM NUMBER 1 ____
CLAIM NUMBER 2 ____
CLAIM NUMBER 3 ____

DATES OF SERVICE:
CLAIM NUMBER 1 ____
CLAIM NUMBER 2 ____
CLAIM NUMBER 3 ____

AWARDS TO MEDICAID CLIENTS - AMOUNTS & DATES PAID
CLAIM NUMBER 1 ____
CLAIM NUMBER 2 ____
CLAIM NUMBER 3 ____

HMO'S DIRECT COSTS (IF ANY)
CLAIM NUMBER 1 ____
CLAIM NUMBER 2 ____
CLAIM NUMBER 3 ____

ATTACH A SUMMARY OF FACTS FOR EACH CASE, DESCRIBING THE CLAIM, THE CAUSES, CIRCUMSTANCES, ETC.

The information reported on this form should come from known malpractice cases of the MCO providers. This may only be applicable if the MCO was named as a participant in the malpractice suit. However, if suits against MCO providers are known, provide us with information on the Medicaid client(s) involved and any large settlements paid when the information is available.

AFC/MOLINA

ATTACHMENT F-4 - PAYMENT METHODOLOGY

The DEPARTMENT agrees to provide a no-loss guarantee to MHU by underwriting any financial losses sustained by MHU for a period of twelve months, beginning July 1, 2002. No later than April 1, 2003, MHU will submit to the DEPARTMENT all paid claims from July 1 through December 31, 2002. The parties will conduct a financial review of MHU's paid claims history from July 1 through December 31, 2002 to determine if the Contract should revert to a risk-based contract effective July 1, 2003.

A. PAYMENT METHODOLOGY

1. EFFECTIVE JULY 1, 2002 THROUGH DECEMBER 31, 2002

The DEPARTMENT shall make interim payments for the months of July 2002 through December 2002 based on the premium methodology in effect on June 30, 2002. MHU must submit to the DEPARTMENT a summary of paid claims on a monthly basis with no more than two months delay after the month being reported. No later then April 1, 2003, MHU will submit to the DEPARTMENT all paid claims from July 1 through December 31, 2002. The payment made to MHU by the DEPARTMENT will be retrospectively adjusted to reflect MHU's actual claim expenditures under this Contract plus 9% of actual claim expenditures to cover administrative costs.

2. EFFECTIVE JANUARY 1, 2003 THROUGH JUNE 30, 2003

The DEPARTMENT will reimburse MHU within 60 days of the month in which MHU paid claims for services rendered under this Contract and will be based on a summary of paid claims data received from MHU. In addition, 9% of actual claim expenditures will be added to the payment for administrative services and patient management expenses incurred by MHU. MHU must submit to the DEPARTMENT the summary of paid claims within 30 days of the month in which MHU paid the claims.

3. RETROSPECTIVE ADJUSTMENT FOR COSTS INCURRED FROM JULY 1, 2002 THROUGH JUNE 30, 2003

Profit sharing occurs if MHU's costs plus 9% administration fee are less than MHU's revenues under this Contract. Revenues are defined as the amount the DEPARTMENT would have paid had this Contract remained a risk contract as

described in 42 CFR 447.361. MHU may retain the savings as follows: if the difference between MHU's costs plus administration and total revenues is 5% or less of total revenues, MHU may retain the entire amount. The portion of savings greater than the 5% shall be shared 50/50 with the DEPARTMENT.

On or before October 1, 2002, MHU will provide to the DEPARTMENT their payment schedule in effect from July 1 through September 30, 2002. Any changes made to MHU's payment schedule must maintain cost neutrality to the DEPARTMENT and are subject to approval by the DEPARTMENT. A final settlement between the parties shall be reconciled within six months of the end of the Contract year.

B. PHARMACY MANAGEMENT INCENTIVE

The DEPARTMENT will establish a target for pharmacy costs for the Contract year. The target will be the historical average cost per member per month (PMPM) for Medicaid client enrolled in MCOs in the previous Contract year. The average cost will be determined for each rate cell. An overall weighted average PMPM pharmacy cost will be established based on MHU's monthly enrollment during the Contract year. The 2002 Contract year's history will be adjusted by the inflation indices published by the US Department of Labor. If actual pharmacy costs for MHU's enrollees are below the target for the Contract year, the savings will be shared [*] with the DEPARTMENT and MHU.

C. CHEC SCREENING INCENTIVE CLAUSE

1. CHEC SCREENING GOAL

The CONTRACTOR will ensure that Medicaid children have access to appropriate well-child visits. The CONTRACTOR will follow the Utah EPSDT (CHEC) guidelines for the periodicity schedule for well-child protocol. The federal agency, Centers for Medicare and Medicaid Services (CMS), mandates that all states have 80% of all children screened. The DEPARTMENT and the CONTRACTOR will work toward that goal.

2. CALCULATION OF CHEC INCENTIVE PAYMENT

The DEPARTMENT will calculate the CONTRACTOR's annual participation rate based on information supplied by the CONTRACTOR under the CMS-416 EPSDT (CHEC) reporting requirements. Based on the CMS-416 data, the CONTRACTOR's well-child participation rate was 97% for Federal Fiscal Year (FFY) 2001 (October 1, 2000 through September 30, 2001). The incentive

payment for the Contract year ending June 30, 2003 will be based on the CONTRACTOR's FFY 2002 (October 1, 2001 through September 30, 2002) CMS-416 participation rate. The DEPARTMENT will pay the CONTRACTOR $[*] if a rate of 90% or higher is maintained during FFY2002. The participation rate will be calculated no later than April 15, 2003; the CONTRACTOR will be notified of the incentive payment, if applicable, no later than April 30, 2003.

3. CONTRACTOR's USE OF INCENTIVE PAYMENT

The CONTRACTOR agrees to use this incentive payment to reward the CONTRACTOR's employees responsible for improving the EPSDT (CHEC) participation rate.

D. IMMUNIZATION INCENTIVE CLAUSE

The CONTRACTOR will ensure that Enrollees have access to recommended immunizations. The CONTRACTOR will follow the Advisory Committee on Immunization Practices' recommendations for immunizations for children.

1. IMMUNIZATIONS FOR TWO-YEAR-OLDS

Utah has achieved a statewide immunization level of 77.4% for two-year-olds. The CONTRACTOR's 2000 HEDIS rate was 46.4% for the Combination 1 immunization measure for two-year olds. Based on the CONTRACTOR's 2001 HEDIS measure for the Combination 1 immunization measure, the DEPARTMENT will pay the CONTRACTOR $[*] for each full percentage point above 46.4% up to 96.4%.

The CONTRACTOR agrees to use this incentive payment to reward the CONTRACTOR's employees responsible for improving the HEDIS rate.

2. IMMUNIZATIONS FOR ADOLESCENTS

The DEPARTMENT realizes it is important that adolescents are vaccinated according to schedule as recommended by the Advisory Committee on Immunization Practices and other professional groups. The CONTRACTOR's 2000 HEDIS rate was 6.8% for the Combination 1 immunization measure for adolescents. Based on the CONTRACTOR's 2001 HEDIS measure for adolescent immunizations, the DEPARTMENT will pay the CONTRACTOR $[*] for each full percentage point above 6.8% up to 56.8%.

The CONTRACTOR agrees to use this incentive payment to reward the CONTRACTOR's employees responsible for improving the HEDIS rate.

3. IMMUNIZATIONS FOR ADULTS

The HEDIS immunization measure for adults is not reported for Medicaid clients age 65 and older. The DEPARTMENT intends to expand this incentive clause to include improved immunization rates for influenza and pneumonia vaccines among Enrollees age 65 and older. The DEPARTMENT will work with contractors to collect this data during this Contract year (July 1, 2002 - June 30, 2003).

CONFIDENTIAL TREATMENT HAS BEEN REQUESTED FOR PORTIONS OF THIS DOCUMENT. PORTIONS FOR WHICH CONFIDENTIAL TREATMENT IS REQUESTED ARE DENOTED BY "[*]". CONFIDENTIAL INFORMATION OMITTED HAS BEEN FILED SEPARATELY WITH THE SECURITIES AND EXCHANGE COMMISSION.

EXHIBIT 10.5

MEMORANDUM OF UNDERSTANDING

This MEMORANDUM OF UNDERSTANDING is made by and between the Utah Department of Health (DEPARTMENT) and Molina Healthcare of Utah, Inc. (MHU), effective July 1, 2002.

RECITALS

A. MHU currently provides services to Medicaid beneficiaries through its Medicaid HMO Contract with the DEPARTMENT.

B. The DEPARTMENT desires to increase the number of Medicaid beneficiaries that receive services through MHU's Medicaid HMO Contract.

C. Following the Utah Legislature's reduction of MHU's rate increase, the DEPARTMENT desires to ensure MHU's financial viability in its role as a Medicaid Managed Care Contractor.

D. The DEPARTMENT requires additional time to draft a formal amendment to the MHU Medicaid HMO Contract, the parties agree to use their best efforts to develop and execute a formal amendment by August 30, 2002.

NOW THEREFORE, the parties enter into this Memorandum of Understanding to set forth their intent and understanding until a formal amendment is developed and executed. Terms not otherwise defined herein shall have the meaning ascribed to them in the MHU Medicaid HMO Contract.

I. MEDICAID HMO

1. MHU will continue to provide necessary covered HMO benefits to those Medicaid beneficiaries enrolled under its Medicaid HMO Contract.
2. The DEPARTMENT agrees to provide a no-loss guarantee to MHU by underwriting any financial losses sustained by MHU for period of twelve (12) months, beginning July 1, 2002. The parties will conduct a financial review, following the first nine (9) months, to determine whether the no-loss guarantee needs to remain in effect beyond the twelve-(12) month period.
3. MHU's Administrative Costs shall not exceed [*] , of Total Medical Costs associated with its Medicaid HMO Contract.
4. If MHU's costs are less than the Total Revenues received from the DEPARTMENT for its Medicaid HMO Contract, including but not limited to Premiums, MHU may retain up to 5% of its profits. Any additional profits above 5%, will be shared with the DEPARTMENT on a 50-50 basis.
5. Pharmacy Management Incentive. The State will establish a "target" for pharmacy costs for FY 2003. The target will be the historical average cost per member per month for clients enrolled in HMOs for FY 2002. The average cost will be

determined for each rate cell. An overall weight average PMPM pharmacy cost will be established based on MHU's enrollment for FY 2003. The pharmacy history will be adjusted for the estimate shift for pharmacy supplies for diabetes. FY 2002 history will be inflated forward by inflation indices published by the US Department of Labor. If actual pharmacy costs are below the target for the year, the savings will be shared 50 - 50.

6. Retroactive Reimbursement. The State will retroactively reimburse actual Medical Costs incurred by Molina for FY 2003 within 60 days of the date of service, nine percent (9%) of Medical Costs incurred will be added to the payment to cover patient management and administrative services. The State will make payment each month based on a summary of paid claims data. An interim payment will be made for the month of July 2002 based on estimated claims expense. After 120 days, the interim payment may be returned at the request of State based on the objective of establishing a 60-day delay between the date of service and the date of payment. A Final Settlement between the parties of Total Revenues shall be reconciled within six months of the completion of this agreement.

II. MEDICAID PPO

1. Once enrollment under the HMO contract reaches 40,000 any additional Medicaid beneficiaries enrolled in the MHU Medicaid HMO Contract will be designated as Medicaid PPO members, governed by the provisions of this section II. If HMO membership falls below 40,000, any new Medicaid enrollees assigned to MHU will be enrolled as HMO enrollees. Once the 40,000 membership level is reached, new Medicaid enrollees assigned to MHU will be enrolled as PPO enrollees.
2. MHU will arrange for the provision of healthcare services, through its HMO contract, for those Medicaid beneficiaries enrolled on a Medicaid PPO basis. The healthcare services will be the same as the Covered Services set forth in MHU's Medicaid HMO Contract.
3. MHU will provide all Administrative Services to its Medicaid PPO enrollees as currently provided under its Medicaid HMO product line, including but not limited to:
   - .Utilization and case management
   - .Claims processing
   - .Member orientations, education and customer services
   - .Provider network development and maintenance.
4. MHU does not assume any financial risk associated with healthcare services provided to its Medicaid PPO enrollees.
5. The DEPARTMENT shall reimburse MHU, all Medical Costs provided to those beneficiaries enrolled in MHU's Medicaid PPO product.
6. The DEPARTMENT will compensate MHU an amount equal to $ [*] per PPO member per month for Administrative Services.

7. Pharmacy Management Incentive. The State will establish a "target" for pharmacy costs for FY 2003. The target will be the historical average cost per member per month for clients enrolled in HMOs for FY 2002. The average cost will be determined for each rate cell. An overall weight average PMPM pharmacy cost will be established based on MHU's enrollment for FY 2003. The pharmacy history will be adjusted for the estimate shift for pharmacy supplies for diabetes. FY 2002 history will be inflated forward by inflation indices published by the US Department of Labor. If actual pharmacy costs are below the target for the year, the savings will be shared 50 - 50.

IN WITNESS WHEREOF, the parties sign this Memorandum of Understanding.

/s/	/s/
Rod Betit	G. Kirk Olsen
Executive Director	CEO
Utah Department of Health	Molina Healthcare of Utah
30 July 2002	30 July 2002

CLIENT SERVICE CONTRACT

DSHS Contract Number: 0312-16028
Resulting From Solicitation Number:

[LOGO OF DEPARTMENT OF SOCIAL AND HEALTH SERVICES]

This Contract is between the State of Washington Department of Social and Health Services (DSHS) and the Contractor identified below.

Program Contract Number:

Contractor Contract Number:

CONTRACTOR NAME	CONTRACTOR doing business as (DBA)
Molina Healthcare of Washington, Inc.	

CONTRACTOR ADDRESS	WASHINGTON UNIFORM BUSINESS IDENTIFIER (UBI)	DSHS INDEX NUMBER
21540 30th Dr. SE, Suite 400 PO Box 1469 Bothell, WA 98041	600-546-648	24261

CONTRACTOR CONTACT	CONTRACTOR TELEPHONE	CONTRACTOR FAX	CONTRACTOR E-MAIL ADDRESS
Peggy Wanta	(425) 424-1146 Ext:	(425) 424-1182	peggyw@molinahealthcare.com

DSHS ADMINISTRATION	DSHS DIVISION	DSHS CONTRACT CODE
Medical Assistance Administration	Program Support	7000XC

DSHS CONTACT NAME AND TITLE	DSHS CONTACT ADDRESS
Michael Paulson MAA Program Manager	P O Box 45530 Olympia, WA 98504-5630

DSHS CONTACT TELEPHONE	DSHS CONTACT FAX	DSHS CONTACT E-MAIL ADDRESS
(360) 725-1641 Ext	(360) 753-7315	paulsmj@dshs.wa.gov

IS THE CONTRACTOR A SUBRECIPIENT FOR PURPOSES OF THIS CONTRACT?	CFDA NUMBER(S)
No	

CONTRACT START DATE	CONTRACT END DATE	CONTRACT MAXIMUM AMOUNT
01/01/2003	12/31/2003	$0.00

EXHIBITS, When the box below is marked with an X, the following Exhibits are attached and are incorporated into this Contract by reference:
[X] Exhibits (specify): A through E

[ILLEGIBLE]

CONTRACTOR SIGNATURE	PRINTED NAME AND TITLE	DATE SIGNED
/s/	Ann Koontz, President & CEO	12-10-02

DSHS SIGNATURE	PRINTED NAME AND TITLE	DATE SIGNED
/s/	Charles H. Pugh, Supervisor Contracts Coordination Unit Medical Assistance Administration	16-Dec-02

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

MEDICAL ASSISTANCE ADMINISTRATION

2003 CONTRACT

FOR

HEALTHY OPTIONS

AND

STATE CHILDREN'S HEALTH INSURANCE PLAN

APPROVED AS TO FORM BY THE ATTORNEY GENERAL'S OFFICE

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1. DEFINITIONS

The following definitions shall apply to this agreement:

1.1. ANCILLARY SERVICES means health services ordered by a provider including but not limited to, laboratory services, radiology services, and physical therapy.

1.2. CHILDREN WITH SPECIAL HEALTH CARE NEEDS means children identified by DSHS to the Contractor as meeting federal guidelines for such children. For the term of this agreement, DSHS will limit such identification to children served under the provisions of Title V of the Social Security Act.

1.3. COMPARABLE COVERAGE means an enrollee has other insurance which DSHS has determined provides a full scope of health care benefits.

1.4. COVERED SERVICES means medically necessary services, as set forth in Section 11, Schedule of Benefits, covered under the terms of this agreement.

1.5. DUAL COVERAGE means an enrollee is privately enrolled on any basis with the Contractor and simultaneously enrolled with the Contractor under Healthy Options/SCHIP.

1.6. EPSDT (Early, Periodic Screening, Diagnosis and Treatment) means a package of services in a preventive (well child) exam covered by Medicaid as defined in the Social Security Act (SSA) Section 1905(r). Services covered by Medicaid include a complete health history and developmental assessment, an unclothed physical exam, immunizations, laboratory tests, health education and anticipatory guidance, and screenings for: vision, dental, substance abuse, mental health and hearing, as well as any medically necessary services found to be necessary during the EPSDT exam. EPSDT services covered by the Contractor are described in Section 11, Schedule of Benefits.

1.7. ELIGIBLE CLIENTS means DSHS clients certified eligible by the DSHS, living in the service area, and eligible to enroll for health care services under the terms of this agreement, as described in Section 2.2.

1.8. EMERGENCY MEDICAL CONDITION means 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: (a) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in

serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part (42 USC 1396u-2(b)(2)(c)).

1.9. ENROLLEE means an individual eligible for any medical program who is enrolled in Healthy Options/SCHIP managed care through a health care plan having an agreement with DSHS.

1.10. MANAGED CARE means a prepaid, comprehensive system of medical and health care delivery, including preventive, primary, specialty and ancillary health services.

1.11. MEDICALLY NECESSARY SERVICES means services which are reasonably calculated to prevent, diagnose, correct, cure, alleviate, or prevent the worsening of conditions that endanger life, cause suffering or pain, result in illness or infirmity, threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the enrollee requesting the service. For the purpose of this agreement, course of treatment may include mere observation or, where appropriate, no treatment at all. Medically necessary services shall include, but not be limited to, diagnostic, therapeutic, and preventive services that are generally and customarily provided in the service area (WAC 388-500-0005.)

1.12. PARTICIPATING PROVIDER means a person, practitioner as defined in the Quality Improvement Program 2003 Standards, Exhibit A, or entity with a written agreement with the Contractor to provide services to enrollees under the terms of this agreement.

1.13. PEER-REVIEWED MEDICAL LITERATURE means medical literature published in professional journals that submit articles for review by experts who are not part of the editorial staff. It does not include publications or supplements to publications primarily intended as marketing material for pharmaceutical, medical supplies, medical devices, health service providers, or insurance carriers.

1.14. PHYSICIAN GROUP means a partnership, association, corporation, individual practice association, or other group that distributes income from the practice among its members. An individual practice association is a physician group only if it is composed of individual physicians and has no subcontracts with physician groups (42 CFR 434.70).

1.15. PHYSICIAN INCENTIVE PLAN means any compensation arrangement between the Contractor and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services to enrollees under the terms of this agreement (42 CFR 434.70).

1.16. PRIMARY CARE PROVIDER (PCP) means a participating provider who has the responsibility for supervising, coordinating, and providing primary health care to enrollees, initiating referrals for specialist care, and maintaining the continuity of enrollee care. PCPs include, but are not limited to Pediatricians, Family Practitioners, General Practitioners, Internists, Physician Assistants (under the supervision of a physician), or Advanced Registered Nurse Practitioners (ARNP), as designated by the Contractor.

1.17. RISK means the possibility that a loss may be incurred because the cost of providing services may exceed the payments made for services (42 CFR 434.2). When applied to subcontractors, loss includes the loss of potential payments made as part of a physician incentive plan, as defined in Section 1.15.

1.18. SERVICE AREA means the geographic area covered by this agreement as described in Section 2.1.

1.19. SCHIP: State Children's Health Insurance Program.

1.20. SUBCONTRACT means a written agreement between the Contractor and a subcontractor, or between a subcontractor and another subcontractor, to perform all or a portion of the duties and obligations the Contractor is obligated to perform pursuant to this agreement.

2. ENROLLMENT

2.1. SERVICE AREAS:

2.1.1. The Contractor's service areas are described in Exhibit D, Premiums, Service Areas, and Capacity.

2.1.2. Clients in the eligibility groups described in Section 2.2 are eligible to enroll with the Contractor if they reside in the Contractor's service areas.

2.1.3. Service Area Changes:

2.1.3.1. With the written approval of DSHS, the Contractor may expand into additional service areas at any time by giving written notice to DSHS, along with evidence, as DSHS may require, to demonstrate the Contractor's ability to support the expansion. DSHS may withhold approval of a requested expansion, if, in DSHS' sole judgment, the requested expansion is not in the best interest of DSHS.

2.1.3.2. The Contractor may decrease service areas by giving DSHS ninety (90) days written notice. The decrease shall not be effective until the first day of the month which falls after the ninety (90) days has elapsed.

2.1.3.3. The Contractor shall notify enrollees affected by any service area decrease sixty (60) calendar days prior to the effective date. Notices must have prior approval of DSHS. If the Contractor fails to notify affected enrollees of a service area decrease sixty (60) calendar days prior to the effective date, the decrease shall not be effective until the first day of the month which falls sixty (60) calendar days from the date the Contractor notifies enrollees.

2.1.4. If the U.S. Postal Service alters the zip code numbers or zip code boundaries within the Contractor's service areas, DSHS shall alter the service area zip code numbers or the boundaries of the service areas with input from the affected contractors.

2.1.5. DSHS shall determine, in its sole judgment, which zip codes fall within each service area. No zip code will be split between service areas.

2.1.6. DSHS will determine whether an enrollee resides within a service area.

2.2. ELIGIBLE CLIENT GROUPS: DSHS shall determine eligibility for enrollment under this agreement. Clients in the following eligibility groups at the time of enrollment are eligible for enrollment under this agreement, and must enroll in Healthy Options/SCHIP unless the enrollee has dual coverage as defined in Section 1.5, has comparable coverage as defined in Section 1.3, or is exempted pursuant to Section 2.4.

2.2.1. Clients receiving Medicaid under Social Security Act (SSA) provisions for coverage of families receiving Temporary Assistance for Needy Families and clients who are not eligible for cash assistance who remain eligible for Medicaid.

2.2.2. Children, from birth through eighteen years of age, eligible for Medicaid under expanded pediatric coverage provisions of the Social Security Act ("H" Children).

2.2.3. Pregnant Women, eligible for Medicaid under expanded maternity coverage provisions of the Social Security Act ("S" women).

2.2.4. Children eligible for SCHIP.

2.3. CLIENT NOTIFICATION: DSHS shall notify eligible clients of their rights and responsibilities as Healthy Options/SCHIP enrollees at the time of initial

eligibility determination and eligibility review. The Contractor shall provide enrollees with additional information as described in this agreement, including the Quality Improvement Program 2003 Standards, Exhibit A.

2.4. EXEMPTION FROM ENROLLMENT: A client may request exemption from enrollment. Each request for exemption will be reviewed by DSHS pursuant to WAC 388-538, Exhibit B or WAC 388-542, Exhibit E. When the client is already enrolled with the Contractor and wishes to be exempted, the exemption request will be treated as a disenrollment request consistent with the provisions of Section 2.9.

2.5. ENROLLMENT PERIOD: Subject to the provisions of Section 2.7, enrollment is continuously open. Enrollees shall have the right to change enrollment prospectively, from one Healthy Options/SCHIP plan to another without cause, each month (42 CFR 434.27).

2.6. ENROLLMENT PROCESS: To enroll with the Contractor, the client, his/her representative or his/her responsible parent or guardian must complete and submit a DSHS enrollment form to DSHS, or call the DSHS, Medical Assistance Administration's (MAA) toll-free enrollment number. If the client does not exercise his/her right to choose a Healthy Options/SCHIP plan, DSHS will assign the client, and all eligible family members, to a Healthy Options/SCHIP plan in accord with section 4.10 of this agreement.

DSHS will make every effort to enroll all family members with the same Healthy Options/SCHIP plan. If a family member is covered by the Basic Health Plan, DSHS will make every effort to enroll the remainder of the family with the same managed care plan if the plan contracts with DSHS to provide Healthy Options/SCHIP. If the plan does not contract with DSHS, the remaining family members will be enrolled with a single, but different Healthy Options/SCHIP plan of the client's choice, or the client will be assigned as described above if they do not choose.

2.7. EFFECTIVE DATE OF ENROLLMENT:

2.7.1. Except for newborns, enrollment with the Contractor shall be effective on the later of the following dates:

2.7.1.1. If the enrollment is processed on or before the DSHS cut-off date for enrollment, enrollment shall be effective the first day of the month following the month in which the enrollment is processed; or

2.7.1.2. If the enrollment is processed after the DSHS cut-off date for enrollment, enrollment shall be effective the first day of the second month following the month in which the enrollment is processed.

2.7.2. Newborns whose mothers are enrollees shall be deemed enrollees and enrolled beginning from the newborn's date of birth or the mother's date of enrollment, whichever is later. If the mother is disenrolled before the newborn receives a separate client identifier from DSHS, the newborn's coverage shall end when the mother's coverage ends, except as provided in Section 3.7.

2.7.3. Adopted children shall be covered consistent with the provisions of Title 48 RCW.

2.7.4. No retroactive coverage is provided under this agreement, except as described in this section.

2.8. ENROLLMENT LISTING AND REQUIREMENTS FOR CONTRACTOR'S RESPONSE:

2.8.1. Before the end of each month DSHS will provide the Contractor with a list of enrollees whose enrollment is terminated the end of that month, and a list of the Contractor's enrollees for the following month.

2.8.2. The Contractor shall have ten (10) calendar days from the receipt of the enrollment listing to notify DSHS in writing of the refusal of an application for enrollment or any discrepancy regarding DSHS' proposed enrollment effective date. Written notice shall include the reason for refusal and must be agreed to by DSHS. The effective date of enrollment specified by DSHS shall be considered accepted by the Contractor and shall be binding if the notice is not timely or DSHS does not agree with the reasons stated in the notice. Subject to DSHS approval, the Contractor may refuse to accept an enrollee for the following reasons:

2.8.2.1. DSHS has enrolled the enrollee with the Contractor in a service area the Contractor is not contracted for.

2.8.2.2. The enrollee is not eligible for enrollment under the terms of this agreement.

2.9. TERMINATION OF ENROLLMENT:

2.9.1. VOLUNTARY TERMINATION: Enrollees may request termination of enrollment by submitting a written request to terminate enrollment to DSHS or by calling the Medical Assistance Customer Service Center (MACSC) toll-free enrollment number. Requests for termination of enrollment may be made to enroll with another Healthy Options plan, or to disenroll from Healthy Options as provided in WAC 388-538, Exhibit B or WAC 388-542, Exhibit E. Except as provided in WAC 388-538, Exhibit B or WAC 388-542, Exhibit E, enrollees whose enrollment is terminated will be prospectively disenrolled. DSHS shall notify the Contractor of enrollee

terminations pursuant to Section 2.8. The Contractor may not request voluntary disenrollment on behalf of an enrollee.

2.9.2. INVOLUNTARY TERMINATION INITIATED BY DSHS FOR INELIGIBILITY: The enrollment of any enrollee under this agreement shall be terminated if the enrollee becomes ineligible for enrollment due to a change in eligibility status.

2.9.2.1. When an enrollee's enrollment is terminated for ineligibility, the termination shall be effective:

2.9.2.1.1. The first day of the month following the month in which the termination is processed by DSHS if the termination is processed on or before the DSHS cut-off date for enrollment or the Contractor is informed by DSHS of the termination prior to the first day of the month following the month in which the termination is processed by DSHS.

2.9.2.1.2. Effective the first day of the second month following the month in which the termination is processed if the termination is processed after the DSHS cut-off date for enrollment and the Contractor is not informed by DSHS of the termination prior to the first day of the month following the month in which the termination is processed by DSHS.

2.9.2.2. Enrollees Eligible for Social Security Income (SSI):

2.9.2.2.1. Enrollees determined by the Social Security Administration (SSA) to be eligible for SSI in calendar year 2003 shall be ineligible for services under the terms of this agreement when DSHS receives the SSI eligibility information from the Social Security Administration through the electronic State Data Exchange (SDX). Such enrollees will be disenrolled prospectively as described in Section 2.9.2.1. DSHS shall not recoup any premiums for enrollees determined SSI eligible effective in 2003 and the Contractor shall be responsible for providing services under the terms of this agreement until the effective date of disenrollment.

2.9.2.2.2. Enrollees determined by the SSA to be eligible for SSI prior to calendar year 2003 shall be ineligible for services under the terms of this agreement when DSHS receives the SSI eligibility information from the Social Security Administration through the electronic State Data Exchange (SDX). Such enrollees will be disenrolled prospectively as described in

Section 2.9.2.1. DSHS shall recoup premiums paid prior to calendar year 2003 in accord with Section 3.5.5.

2.9.2.2.3. If the Contractor believes an enrollee has been determined by SSA to be eligible for SSI, the Contractor shall present documentation of such eligibility to DSHS, DSHS will attempt to verify the eligibility and, if the enrollee is SSI eligible, DSHS will act upon SSI eligibility in accord with this section.

2.9.3. INVOLUNTARY TERMINATION INITIATED BY DSHS FOR COMPARABLE COVERAGE OR DUAL COVERAGE:

2.9.3.1. The Contractor shall notify DSHS as set forth below when an enrollee has health care insurance coverage with the Contractor or any other carrier:

2.9.3.1.1. Within fifteen (15) working days when an enrollee is verified as having dual coverage, as defined in Section 1.5.

2.9.3.1.2. Within sixty (60) calendar days of when the Contractor becomes aware that an enrollee has any health care insurance coverage with any other insurance carrier. The Contractor is not responsible for the determination of comparable coverage, as defined in Section 1.3.

2.9.3.2. DSHS will involuntarily terminate the enrollment of any enrollee with dual coverage or comparable coverage as follows:

2.9.3.2.1. When the enrollee has dual coverage which has been verified by DSHS, DSHS shall terminate enrollment retroactively to the beginning of the month of dual coverage and recoup premiums as describe in Section 3.5.

2.9.3.2.2. When the enrollee has comparable coverage which has been verified by DSHS, DSHS shall terminate enrollment effective the first day of the second month following the month in which the termination is processed if the termination is processed on or before the DSHS cut-off date for enrollment or, effective the first day of the third month following the month in which the termination is processed if the termination is processed after the DSHS cut-off date for enrollment.

2.9.4. INVOLUNTARY TERMINATION INITIATED BY THE CONTRACTOR: To request involuntary termination of an enrollee, the Contractor must send written notice to DSHS as described in Section 7.5. DSHS shall approve or disapprove the request for termination within thirty (30) working days of receipt of such notice. For the termination to be effective, DSHS must approve the termination request, notify the Contractor, and disenroll the enrollee. The Contractor shall continue to provide services to the enrollee until s/he is disenrolled. DSHS will not disenroll an enrollee solely due to a request based on an adverse change in the enrollee's health status or the cost of meeting the enrollee's health care needs (WAC 388-538-130, Exhibit B). DSHS shall involuntarily terminate the enrollee when the Contractor has substantiated in writing:

2.9.4.1. The enrollee's behavior is inconsistent with the Contractor's rules and regulations, such as intentional misconduct.

2.9.4.2. The Contractor has provided a clinically appropriate evaluation to determine whether there is a treatable condition contributing to the enrollee's behavior and such evaluation either finds no treatable condition to be contributing, or, after evaluation and treatment, the enrollee's behavior continues to prevent the provider from safely or prudently providing medical care to the enrollee.

2.9.4.3. The enrollee received written notice from the Contractor of its intent to request the enrollee's disenrollment, unless the requirement for notification has been waived by DSHS because the enrollee's conduct presents the threat of imminent harm to others. The Contractor's notice to the enrollee must include the following:

2.9.4.3.1. The enrollee's right to use the Contractor's appeal process to review the request to end the enrollee's enrollment.

2.9.4.3.2. The enrollee's right to use the DSHS fair hearing process.

2.9.5. An enrollee whose enrollment is terminated for any reason, other than incarceration, at any time during the month is entitled to receive covered services, as described in Section 10.1, at the Contractor's expense, through the end of that month.

In no event will an enrollee be entitled to receive services and benefits under this agreement after the last day of the month in which his or her enrollment is terminated, except as provided in Section 3.7.

3. PAYMENT

3.1. RATES/PREMIUMS: Subject to the provisions of Section 7.7, Intermediate Sanctions, DSHS shall pay a monthly premium for each enrollee in full consideration of the work to be performed by the Contractor under this agreement. DSHS shall pay the Contractor, on or before the tenth (10th) working day of the month based on the DSHS list of enrollees whose enrollment is ongoing or effective on the first day of said calendar month. Such payment will be denied for new enrollees when, and for so long as, payment for those enrollees is denied by the Centers for Medicare and Medicaid Services (CMS) under 42 CFR 434.67(e) (42 CFR 434.22).

The Contractor shall reconcile the payment listing with remittance advice information and submit a claim to DSHS for any amount due the Contractor within three hundred sixty five (365) calendar days of the month of service. When DSHS' records confirm the Contractor's claim, DSHS shall remit payment within thirty (30) calendar days of the receipt of the claim.

3.1.1. The statewide Base Rate is $129.88.

3.1.2. The Geographical Adjustment Factors and First Quarter Risk Adjustment Factors are in Exhibit D, Premiums, Service Areas, and Capacity.

3.1.3. The Age/Sex Adjustment Factors are as follows:

	Males	Females
Under age 1	2.778	2.778
Ages 1-2	0.899	0.899
Ages 3-14	0.468	0.468
Ages 15-18	0.531	1.872
Ages 19-34	0.847	2.314
Ages 35-64	1.639	2.057
Age 65 and over	4.247	4.247

3.1.4. The monthly premium payment will be calculated as follows:

Premium Payment = Base Rate X Age/Sex Factor X Risk Adjustment Factor X Geographical Adjustment Factor

3.1.5. The Risk Adjustment Factor will be recalculated for premiums paid for May 2003 based on enrollment with the Contractor on March 1, 2003 using encounter data reported for the 12 months ending June 30, 2002. The recalculated Risk Adjustment Factor shall be used by DSHS to calculate premiums for May through December of 2003. DSHS shall

update Exhibit D, Premiums, Service Areas, and Capacity to add the third quarter Risk Adjustment Factor.

3.1.6. DSHS shall automatically generate newborn premiums whenever possible. For newborns whose premiums DSHS is not able to automatically generate the Contractor shall submit a supplemental premium payment request to DSHS within 365 days of the month of service. The Contractor shall be responsible for reviewing monthly listings provided by DSHS of the newborn premiums DSHS cannot generate automatically, as well as remittance advice statements, to determine whether a supplemental premium request needs to be submitted. DSHS shall pay supplemental premiums through the end of the month in which the sixtieth (60th) day of life occurs.

3.1.7. DSHS shall make a full monthly payment to the Contractor for the month in which an enrollee's enrollment is terminated except as otherwise provided herein.

3.1.8. The Contractor shall be responsible for covered medical services provided to the enrollee in any month for which DSHS paid the Contractor for the enrollee's care under the terms of this agreement.

3.2. DELIVERY CASE RATE PAYMENT: A one-time payment of $4,300.00 shall be made to the Contractor for labor and delivery expenses for enrollees enrolled with the Contractor during the month of delivery. Delivery includes both live and still births, but does not include miscarriage, induced abortion, or other fetal demise not requiring labor and delivery to terminate the pregnancy. The Contractor shall submit a supplemental premium request for payment to DSHS after the enrollee delivers.

3.3. RENEGOTIATION OF RATES: The base rate set forth in Section 3.1 shall be subject to renegotiation during the agreement period only if DSHS, in its sole judgment, determines that it is necessary due to a change in federal or state law or other material changes, beyond the Contractor's control, which would justify such a renegotiation.

3.4. REINSURANCE/RISK PROTECTION: The Contractor may obtain reinsurance for coverage of enrollees only to the extent that it obtains such reinsurance for other groups enrolled by the Contractor, provided that the Contractor remains ultimately liable to DSHS for the services rendered.

3.5. RECOUPMENTS: Unless mutually agreed to by the parties, DSHS shall only recoup premium payments for enrollees who are:

3.5.1. Dually-covered with the Contractor.

3.5.2. Deceased prior to the month of enrollment. Premium payments shall be recouped effective the first day of the month following the enrollee's date of death.

3.5.3. Retroactively disenrolled as a result of the enrollee's placement in foster care.

3.5.4. Retroactively disenrolled consistent with the provisions of Section 2.9.1.

3.5.5. Determined to have been eligible for SSI prior to calendar year 2003 in accord with Section 2.9.2.2.2. DSHS shall recoup calendar year 2002 premiums paid in and subsequent to the month of SSI eligibility. DSHS shall only recoup premiums paid in 2002.

3.5.6. Found ineligible for enrollment with the Contractor and DSHS so notifies the Contractor before the first day of the month for which the premium is paid.

3.5.7. The Contractor may recoup payments made to providers for services provided to enrollees during the period for which DSHS recoups premiums for those enrollees. If the Contractor recoups said payments, providers may submit appropriate claims for payment to DSHS through its FFS program.

3.6. ENROLLEE HOSPITALIZED AT ENROLLMENT: If an enrollee is in an acute care hospital at the time of enrollment and was not enrolled in Healthy Options/SCHIP on the day s/he was admitted to the hospital, DSHS shall be responsible for payment of all inpatient facility and professional services provided from the date of admission until the date the enrollee is no longer confined to an acute care hospital. If the enrollee was enrolled in Healthy Options/SCHIP on the day s/he was admitted to the hospital, then the plan the enrollee was enrolled with on the date of admission shall be responsible for payment until the date the enrollee is no longer confined to an acute care hospital. For newborns born while their mother is hospitalized, the party responsible for the payment for the mother's hospitalization shall be responsible for payment of all inpatient facility and professional services provided to the newborn from the date of admission until the date the newborn is no longer confined to an acute care hospital. If DSHS is responsible for payment of all inpatient facility and professional services provided to a mother and newborn, DSHS shall not pay the Contractor a Delivery Case Rate under the provisions of Section 3.2.

3.7. ENROLLEE HOSPITALIZED AT DISENROLLMENT: If an enrollee is in an acute care hospital at the time of disenrollment and the enrollee was enrolled with the Contractor on the date of admission, the Contractor shall be responsible for payment of all covered inpatient facility and professional services from the

date of admission to the date the enrollee is no longer confined to an acute care hospital.

3.8. THIRD-PARTY LIABILITY (TPL): Until such time as DSHS shall terminate the enrollment of an enrollee who has comparable coverage as described in Section 2.9.3., the services and benefits available under this agreement shall be secondary to any other medical coverage. The Contractor shall:

3.8.1. Not refuse or reduce services provided under this agreement solely due to the existence of similar benefits provided under any other health care contracts (RCW 48.21.200), except in accordance with applicable coordination of benefits rules in WAC 284-51.

3.8.2. Attempt to recover any third-party resources available to enrollees (42 CFR 433 Subpart D) and shall make all records pertaining to TPL collections for enrollees available for audit and review.

3.8.3. Pay claims for prenatal care and preventive pediatric care and then seek reimbursement from third parties (42 CFR 433.139(b)(3)).

3.8.4. Pay claims for covered services when probable third party liability has not been established or the third party benefits are not available to pay a claim at the time it is filed (42 CFR 433.139(c)).

3.8.5. Communicate the requirements of this section to subcontractors that provide services under the terms of this agreement, and assure compliance with them.

3.9. SUBROGATION RIGHTS OF THIRD-PARTY LIABILITY: Injured person means an enrollee covered by this agreement who sustains bodily injury. Contractor's medical expense means the expense incurred by the Contractor for the care or treatment of the injury sustained computed in accordance with the Contractor's fee-for-service schedule.

If an enrollee requires medical services from the Contractor as a result of an alleged act or omission by a third-party giving rise to a claim of legal liability against the third-party, the Contractor shall have the right to obtain recovery of its cost of providing benefits to the injured person from the third-party. DSHS specifically assigns to the Contractor the DSHS' rights to such third party payments for medical care provided to an enrollee on behalf of DSHS, which the enrollee assigned to DSHS as provided in WAC 388-505-0540.

DSHS also assigns to the Contractor its statutory lien under RCW 43.20B.060. The Contractor shall be subrogated to the DSHS' rights and remedies under RCW 74.09.180 and RCW 43.20B.040 through RCW

43.20B.070 with respect to medical benefits provided to enrollees on behalf of DSHS under RCW 74.09.

The Contractor may obtain a signed agreement from the enrollee in which the enrollee agrees to fully cooperate in effecting collection from persons causing the injury. The agreement may provide that if an injured party settles a claim without protecting the Contractor's interest, the injured party shall be liable to the Contractor for the full cost of medical services provided by the Contractor. The Contractor shall notify DSHS of the name, address, and other identifying information of any enrollee and the enrollee's attorney who settles a claim without protecting the Contractor's interest in contravention of RCW 43.20B.050.

4. ACCESS AND CAPACITY

4.1. NETWORK CAPACITY:

4.1.1. The Contractor agrees to maintain the support services and a provider network sufficient to serve the enrollee capacity stated in Exhibit D, Premiums, Service Areas, and Capacity, consistent with the requirements of this agreement. The Contractor agrees to provide the medical services required by this agreement through non-participating providers if its network of participating providers is insufficient to meet the medical needs of enrollees in a manner consistent with this agreement.

4.1.2. With the written approval of DSHS, the Contractor may increase capacity at any time by giving written notice to DSHS, along with evidence, as DSHS may require, demonstrating the Contractor's ability to support the capacity increase. DSHS may withhold approval of a requested capacity increase, if, in DSHS' sole judgment, the requested increase is not in the best interest of DSHS. The Contractor may decrease capacity by giving DSHS ninety (90) days written notice. The decrease shall not be effective until the first day of the month which falls after the ninety (90) days has elapsed. Exhibit D, Premiums, Service Areas, and Capacity will be updated by DSHS for increases and decreases in capacity.

4.2. ACCESSIBILITY OF SERVICES: The Contractor shall make services accessible consistent with the provisions in the Quality Improvement Program 2003 Standards, Exhibit A. The Contractor shall make covered services as accessible to enrollees under this agreement as under its other state, federal, or private contracts.

4.3. 24/7 AVAILABILITY: The Contractor shall have the following services available on a 24-hour-a-day, seven-day-a-week basis by telephone. These services

may be provided directly by the Contractor or may be delegated to subcontractors.

4.3.1. Medical advice for enrollees from licensed health care professionals concerning the emergent, urgent or routine nature of medical condition.

4.3.2. Authorization of emergency services and out-of-area urgent care.

4.4. APPOINTMENT STANDARDS: The Contractor shall comply with appointment standards that are no longer than the following:

4.4.1. Non-symptomatic (i.e. preventive care) office visits shall be available from the enrollee's PCP or an alternative practitioner within thirty (30) calendar days. A non-symptomatic office visit may include, but is not limited to, well/preventive care such as physical examinations, annual gynecological examinations, or children and adult immunizations.

4.4.2. Non-urgent, symptomatic (i.e., routine care) office visit shall be available from the enrollee's PCP or an alternative practitioner within seven (7) calendar days. A non-urgent, symptomatic office visit is associated with the presentation of medical signs not requiring immediate attention.

4.4.3. Urgent, symptomatic office visits shall be available within 24 hours. An urgent, symptomatic visit is associated with the presentation of medical signs that require immediate attention, but are not life threatening.

4.4.4. Emergency medical care shall be available 24 hours per day, seven days per week.

4.5. PROVIDER NETWORK - DISTANCE STANDARDS: The Contractor network of providers shall meet the distance standards below in every service area. The designation of a zip code in a service area as rural or urban is in Exhibit D, Premiums, Service Areas, and Capacity. DSHS may, at its sole discretion, grant exceptions to the distance standards. DSHS' approval of an exception must be in writing. The Contractor shall request an exception in writing and shall provide evidence as DSHS may require to support the request. If the closest qualified provider is beyond the distance standard applicable to the zip code, the distance standard defaults to the distance to that provider. The closest qualified provider may be a provider not participating with the Contractor.

4.5.1. PCP

Urban: 2 within 10 miles for 90% of Healthy Options enrollees in the Contractor's service area

Rural: 1 within 25 miles for 90% of Healthy Options enrollees in the contractor's service area

4.5.2. Obstetrics

Urban: 2 within 10 miles for 90% of Healthy Options enrollees in the contractor's service area

Rural: 1 within 25 miles for 90% of Healthy Options enrollees in the contractor's service area

4.5.3. Pediatrician

Urban: 2 within 10 miles for 90% of Healthy Options enrollees in the contractor's service area

Rural: 1 within 25 miles for 90% of Healthy Options enrollees in the contractor's service area

4.5.4. Hospital

Urban/Rural: 1 within 25 miles for 90% of Healthy Options enrollees in the contractor's service area

4.5.5. Pharmacy

Urban: 1 within 10 miles for 90% of Healthy Options enrollees in the contractor's service area

Rural: 1 within 25 miles for 90% of Healthy Options enrollees in the contractor's service area

4.6. ACCESS TO SPECIALTY CARE: The Contractor shall provide all medically necessary specialty care for enrollees in a service area. If an enrollee needs specialty care from a specialist who is not available within the Contractor's provider network, the Contractor shall provide the necessary services with a qualified specialist outside the Contractor's provider network.

4.7. EQUAL ACCESS FOR ENROLLEES WITH COMMUNICATION BARRIERS: The Contractor shall assure equal access for all enrollees when oral or written language creates a barrier to such access for Enrollees with Communication Barriers

4.7.1. ORAL INFORMATION:

4.7.1.1. The Contractor shall assure that interpreter services are provided for enrollees with a primary language other than English for all interactions between the enrollee and the Contractor or any of its providers including, but not limited to, all appointments with any provider for any covered service, emergency services, and all steps necessary to file complaints and appeals.

4.7.1.2. The Contractor is responsible for payment for interpreter services for plan administrative matters including, but not limited to handling enrollee complaints and appeals.

4.7.1.3. DSHS is responsible for payment for interpreter services provided by interpreter agencies contracted with the state for outpatient medical visits and DSHS fair hearings.

4.7.1.4. Hospitals are responsible for payment for interpreter services during inpatient stays.

4.7.1.5. Public entities are responsible for payment for interpreter services provided at their facilities or affiliated sites.

4.7.1.6. Interpreter services include the provision of interpreters for enrollees who are deaf or hearing impaired.

4.7.2. WRITTEN INFORMATION:

4.7.2.1. The Contractor shall provide all generally available and client specific written materials in a form which may be understood by each individual enrollee. The Contractor may meet this requirement by doing one of the following:

4.7.2.1.1. Translating the material into the enrollee's primary reading language.

4.7.2.1.2. Providing the material on tape in the enrollee's primary language.

4.7.2.1.3. Having an interpreter read the material to the enrollee in the enrollee's primary language.

4.7.2.1.4. Providing the material in another alternative medium or format acceptable to the enrollee. The Contractor must document the enrollee's acceptance of the alternative.

4.7.2.1.5. Providing the material in English, if the Contractor documents the enrollee's preference for receiving material in English.

4.7.2.2. The Contractor shall ensure that all written information provided to enrollees is comprehensible to its intended audience, designed to provide the greatest degree of understanding, and is written at the sixth grade reading level. Generally available, written materials shall be consumer tested.

4.8. AMERICANS WITH DISABILITIES ACT: The Contractor shall make reasonable accommodation for enrollees with disabilities, in accord with the Americans with Disabilities Act, for all covered services and shall assure physical and communication barriers shall not inhibit enrollees with disabilities from obtaining covered services.

4.9. CAPACITY LIMITS AND ORDER OF ACCEPTANCE: The Contractor shall provide care to enrollees up to the capacity limits in Exhibit D, Premiums, Service Areas, and Capacity. The Contractor shall accept enrollees up to the total capacity limit in each service area, and enrollees will be accepted in the order in which they apply. DSHS shall enroll all eligible clients with the contractor of their choice if the contractor has not reached the capacity limit unless DSHS determines, in its sole judgment, that it is in DSHS' best interest to withhold or limit enrollment with the Contractor. The Contractor shall accept clients who are assigned by DSHS in accordance with this agreement, WAC 388-538, Exhibit B, and WAC 388-542, Exhibit E, except as specifically provided in Section 2.8.

No eligible client shall be refused enrollment or re-enrollment, have his/her enrollment terminated, or be discriminated against in any way because of his/her health status, the existence of a pre-existing physical or mental condition, including pregnancy and/or hospitalization, or the expectation of the need for frequent or high cost care.

4.10. ASSIGNMENT OF ENROLLEES:

4.10.1. Enrollees who do not select a plan in a service area identified by DSHS as having mandatory enrollment into managed care shall be assigned to a plan in the following manner:

4.10.1.1 DSHS shall determine the total capacity of all contractors receiving assignments in each service area.

4.10.1.2. The Contractor's capacity in each service area, as stated in Exhibit D, Premiums, Service Areas, and Capacity, modified by increases and decreases in capacity made in accord with this agreement,

shall be divided by the total capacity of all contractors receiving assignment in each service area.

4.10.1.3. The result of the calculation in 4.10.1.2. will be multiplied by the total of the households to be assigned.

4.10.1.4. DSHS shall assign the number of households determined in 4.10.1.3. to the Contractor.

4.10.2. DSHS shall not make any assignments of enrollees to the Contractor in a service area if the Contractor's enrollment, when DSHS calculates assignments, is ninety percent (90%) or more of its capacity in that service area.

4.10.3. The Contractor may choose not to receive assignments or limit assignments in any service area by so notifying DSHS in writing at least seventy-five (75) days before the first of the month it is requesting not to receive assignment of enrollees.

4.10.4. DSHS reserves the right to make no assignments, or to withhold or limit assignments to the Contractor, when, in its sole judgment, it is in the best interest of DSHS.

4.10.5. If either the Contractor or DSHS limits assignments as described herein, the Contractor's capacity, only for the purposes of the calculation in 4.10.1.2., shall be that limit.

4.10.6. Assigned enrollees are notified by DSHS of their assignment and may choose a different managed care organization prior to the effective date of their assignment.

4.11. PROVIDER NETWORK CHANGES:

4.11.1. The Contractor shall give DSHS a minimum of ninety (90) calendar days prior written notice, in accordance with Section 7.5, Notices, of the loss of a material provider. A material provider is one whose loss would impair the Contractor's ability to provide continuity of and access to care for the Contractor's current enrollees and/or the number of enrollees the Contractor has agreed to serve in a service area.

4.11.2. The Contractor shall notify enrollees affected by any provider termination sixty (60) calendar days prior to the effective date. Notices must have prior approval of DSHS. If the Contractor fails to notify affected enrollees of a provider termination sixty (60) calendar days prior to the effective date, the Contractor shall allow affected enrollees to continue to receive services from the terminating provider, at the

enrollees' option, and administer benefits for the lessor of a period ending the last day of the month in which sixty (60) calendar days elapses from the date the Contractor notifies enrollees or the enrollee's effective date of enrollment with another plan.

4.12. WOMEN'S HEALTH CARE SERVICES: In the provision of women's health care services, the Contractor shall comply with the provisions of WAC 284-43-250, as modified.

4.13. MATERNITY NEWBORN LENGTH OF STAY: The Contractor shall ensure that hospital delivery maternity care is provided in accordance with RCW 48.43.115.

5. QUALITY OF CARE

5.1. QUALITY IMPROVEMENT PROGRAM: The Contractor shall maintain a quality improvement program that meets the requirements of the Quality Improvement Program 2003 Standards, Exhibit A. The Contractor shall, during the annual TEAMonitor visit or upon request by DSHS, provide evidence of how data and information provided by DSHS, including external quality review findings, agency audits and contract monitoring activities, enrollee complaint and CAHPS(R) results, are used to identify and correct problems and to improve care and services to enrollees.

5.2. ACCREDITATION: If the Contractor has had an accreditation visit by NCQA or other accrediting body, the Contractor shall make the complete accreditation survey report from the accreditation organization available to DSHS upon request. The Contractor shall allow a state representative to accompany any accreditation review team during the site visit in an official observer status. The state representative shall be allowed to share information with DSHS and Health Care Authority staff as needed to reduce duplicated work for both the Contractor and the state.

5.3. REQUIREMENTS FOR DENIED, DISCONTINUED, OR MODIFIED SERVICE:

5.3.1. If the Contractor denies, discontinues, or modifies a service, the Contractor shall comply with the notice requirements in the Quality Improvement Program 2003 Standards, Exhibit A, and any other pertinent provisions of this agreement, in providing notice to enrollees and providers.

5.3.2. If the notice does not meet the timeliness standards in the Quality Improvement Program 2003 Standards, Exhibit A, and any other pertinent provisions of this agreement, the Contractor shall cover the service.

5.3.3. If the Contractor denies, discontinues or modifies a medically necessary covered service because the enrollee's whereabouts are unknown, the Contractor shall reinstate the service when the enrollee's whereabouts become known.

5.3.4. If the enrollee receives the service before receiving the notice, the Contractor shall cover the service.

5.3.5. If an enrollee files an appeal, including independent review, or DSHS fair hearing on a service that is being discontinued or modified, the Contractor shall continue to provide the discontinued or modified service until a final decision is made.

5.3.6. The Contractor may seek reimbursement of the amount it actually paid to continue to provide discontinued or modified services, while such services are the subject of an appeal, including independent review, or DSHS fair hearing, if the final decision determines that the services are non-covered services and if the affected enrollee is fully informed in writing, in advance of receiving the continued services, that they will be required to pay for continued services determined to be non-covered.

5.3.7. Sections 5.3.1., 5.3.2., 5.3.3., 5.3.4., 5.3.5., and 5.3.6. only apply to denial, discontinuance, or modification of services of participating providers, services from a provider to whom the Contractor or a participating provider has made a referral, services previously authorized by the Contractor, and emergency medical services as described in the Schedule of Benefits Section 11.1.6.

5.4. ENROLLEE COMPLAINTS AND APPEALS, INCLUDING INDEPENDENT REVIEW: The Contractor shall maintain a process that meets the requirements in the Quality Improvement Program Standards and other pertinent provisions of this agreement for responding to enrollee complaints and appeals. DSHS shall approve, in writing, all policies and procedures regarding complaints and appeals. All procedures for responding to appeals shall include the participation of individuals with authority to require corrective action (42 CFR 434.32 (c)).

The Contractor shall also comply with the provisions of WAC 284-43-630 regarding independent review of adverse determinations by an independent review organization.

5.5. FAIR HEARING:

5.5.1. Enrollees may request a DSHS fair hearing, pursuant to WAC 388-02, without first availing themselves of the Contractor's complaint and appeal

process, if the subject matter is one for which the enrollee has a fair hearing right under RCW 34.05, and WAC 388-02 or WAC 388-538.

5.5.2. If the enrollee requests a DSHS fair hearing without first exhausting the remedies available to the enrollee through the Contractor's complaint and appeal process, including independent review, and DSHS issues a fair hearing determination, the fair hearing shall exhaust the enrollee's rights to administrative review of the subject of the fair hearing, except as provided in section 5.5.6.

5.5.3. If the enrollee requests a fair hearing, the Contractor shall provide to DSHS, at DSHS' written request, Contractor-held documentation related to the complaint/appeal, if any, including but not limited to, any transcript(s), records, or written decision(s) from participating providers or delegated entities. The Contractor shall have the opportunity to present its position at the fair hearing. The Contractor's medical director or designee shall review all cases where a fair hearing is requested and any related appeals, when medical necessity is an issue.

5.5.4. When an enrollee requests a fair hearing with DSHS, DSHS shall review the request, as follows:

5.5.4.1. A program manager will investigate and determine the facts of the complaint/appeal. The program manager may hold a pre-hearing conference with the enrollee to clarify the issue(s). Other parties may be contacted as appropriate to resolve the complaint/appeal. Other staff of DSHS may be involved as necessary. The DSHS, MAA Medical Director shall review any issue(s) involving denied medical services.

5.5.4.2. Based on the review of facts, the program manager will respond to the complaint/appeal. The response may include, but not be limited to, clarification of program policy to parties who have not acted in accord with the policy.

5.5.4.3. If the matter is not resolved at a pre-hearing conference, the program manager will prepare a written report of the results of the review for the administrative law judge. The report and all supporting documentation will be sent to the enrollee, the enrollee's representative, if any, and the Contractor.

5.5.5. DSHS shall notify the Contractor of fair hearing determinations. The Contractor shall be bound by the fair hearing determination, whether or not the fair hearing determination upholds the Contractor's decision. Implementation of such fair hearing decision shall not be the basis for disenrollment of the enrollee by the Contractor.

If the fair hearing decision is not within the purview of this agreement, then DSHS shall be responsible for the implementation of the fair hearing decision.

5.5.6. An enrollee who is aggrieved by the final decision in the DSHS' fair hearing proceeding may appeal the decision in accordance with WAC 388-02-0560--388-02-0590. Notice of this right will be included in the written determination from the administrative law judge.

5.6. EPSDT/CHILDHOOD IMMUNIZATION:

5.6.1. The Contractor shall meet all requirements under the DSHS EPSDT program policy and billing instructions manual.

5.6.2. If any of the Contractor's Health Plan Employer Data and Information Set (HEDIS(R)) Infant Well Child Visit, Child Well Child Visit, Adolescent Well Child Visit, or Childhood Immunization reported rates fall below 60%, the Contractor shall include an appropriate quality improvement project designed to improve the rates in the Contractor's Quality Improvement work plan and shall implement appropriate intervention.

5.6.3. Active Participation in a DSHS sponsored well child quality improvement program or an appropriate alternative program approved by DSHS, MAA Quality Management fulfills the requirement under Section 5.6.2. Alternative programs must document: a description and scope of the program with identified problem(s), goals and objectives; a workplan with specific QI activities, timeframes and person(s) responsible for each; sound measurement methodology; barrier and root cause analysis; an evaluation of outcomes; and re-measurement and strong interventions designed to improve outcomes.

5.7. PROVIDER EDUCATION: The Contractor shall maintain a system for keeping participating practitioners and providers informed about:

5.7.1. Covered services for enrollees served under this agreement

5.7.2. Coordination of care requirements; and

5.7.3. DSHS policies as related to this agreement.

5.7.4. Interpretation of data from the quality improvement program (42 CFR 434.34(d)).

5.8. CLAIMS PAYMENT STANDARDS: The Contractor shall meet the timeliness of payment standards specified for Medicaid fee-for-service in Section

1902(a)(37)(A) of the Social Security Act and specified for health carriers in WAC 284-43-321. To be compliant with both payment standards the Contractor shall pay or deny, and shall require subcontractors to pay or deny, 95% of clean claims within thirty (30) calendar days of receipt, 95% of all claims within sixty (60) of receipt and 99% of all claims within ninety (90) calendar days of receipt. The Contractor and its providers may agree to a different payment requirement in writing on an individual claim.

5.9. QUALITY IMPROVEMENT STUDIES: The Contractor shall conduct three quality improvement studies.

5.9.1. Two studies shall be based upon the following questions from the 2002 CAHPS(R) survey:

5.9.1.1. In the last 6 months, how often were office staff at your child's doctor's office or clinic as helpful as you thought they should be?

5.9.1.2. In the last 6 months, when your child needed care right away for an illness or an injury, how often did your child get care as soon as you wanted?

5.9.1.3. The requirement for either of the two studies shall be waived by DSHS if the Contractor's unadjusted percentages for the response rate of "Always" are above the 2001 National Committee's Benchmarking Database (NCBD) data. Sixty-one percent is the benchmark for the question in Section 5.9.1,1. and sixty-seven percent is the benchmark for the question in Section 5.9.1.2. DSHS will notify the Contractor in writing if the requirement is waived.

5.9.2. The Contractor shall participate in a third statewide quality improvement study designated by DSHS. The study shall be designed to maximize resources and reduce cost to contractors.

5.10. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA): The Contractor shall comply with the applicable provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, codified at 42 USC 1320(d) et.seq. and 45 CFR parts 160, 162, and 164. HIPAA requires the Contractor to conduct electronic financial and administrative transactions using a mandatory format and content. The Contractor must have the capacity to conduct all transactions required by HIPAA, including but not limited to the ability to accept the following transactions from the Medical Assistance Administration:

5.10.1. The ASC X12 834 - Benefit Enrollment and Maintenance Version 4010.

5.10.2. The ASC X12 820 - Payroll Deducted and Other Group Premium Payment for Insurance Products, Version 4010 Premium Payment transaction.

5.11. PRACTICE GUIDELINES: The Contractor shall adopt of practice guidelines that meet the following requirements (42 CFR 438.6):

5.11.1. Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field.

5.11.2. Consider the needs of enrollees.

5.11.3. Are adopted in consultation with contracting health care professionals.

5.11.4. Are reviewed and updated periodically as appropriate.

5.11.5. Are disseminated to all affected providers and, upon request, to DSHS, enrollees and potential enrollees.

5.11.6. Are the basis for and are consistent with decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply.

5.12. ADVANCE DIRECTIVES: The Contractor shall maintain written policies and procedures for advance directives with meet the requirements of WAC 388-501-0125 and 42 CFR 438.6. The Contractor's Advance directive policies and procedure shall be disseminated to all affected providers and, upon request, to DSHS, enrollees and potential enrollees.

6. REPORTING REQUIREMENTS:

6.1. CERTIFICATION REQUIREMENTS: Any information and/or data required by this agreement and submitted to DSHS after March 31, 2003 must be certified by the Contractor as follows (42 CFR 438.600 through 42 CFR 438.606):

6.1.1. Source of certification: The information and/or data must be certified by one of the following:

6.1.1.1. The Contractor's Chief Executive Officer

6.1.1.2. The Contractor's Chief Financial Officer

6.1.1.3. An individual who has delegated authority to sign for, and who reports directly to, the Contractor's Chief Executive Officer or Chief Financial Officer

6.1.2. Content of certification: The Contractor's certification shall attest, based on best knowledge, information, and belief, to the accuracy, completeness and truthfulness of the information and/or data.

6.1.3. Timing of certification: The Contractor shall submit the certification concurrently with the certified information and/or data.

6.2. HEDIS(R) MEASURES: The Contractor shall report to DSHS (for both Healthy Options and SCHIP enrollees), the following HEDIS(R) measures in accord with the published HEDIS(R) 2003 Technical Specifications and official corrections published by NCQA, unless directed otherwise in writing by DSHS.

6.2.1. No later than June 30, 2003, the following HEDIS(R) measures shall be submitted electronically to DSHS using the NCQA data submission tool (DST):

6.2.1.1. Childhood Immunization Status

6.2.1.2. Prenatal and Postpartum Care

6.2.1.3. Well Child Visits in the First 15 Months of Life

6.2.1.4. Well Child Visits in the Third, Fourth, Fifth and Sixth Years of Life

6.2.1.5. Adolescent Well Child Visits

6.2.1.6. Use of Appropriate Medications for People with Asthma

6.2.1.7. Antidepressant Medication Management

6.2.1.8. Inpatient Utilization-General Hospital/Acute Care

6.2.1.9. Ambulatory Care

6.2.1.10. Birth and Average Length of Stay, Newborns

6.2.2. All measures shall be audited, at Contractor expense, by an NCQA licensed organization in accord with the HEDIS 2003 COMPLIANCE AUDIT (TM) standards, policies and procedures. The signed and certified audit report shall be submitted to DSHS no later than July 31, 2003.

6.2.2.1. If the Contractor has current NCQA accreditation, including Medicaid, a full audit, as defined by NCQA, is allowed.

6.2.2.2. If the Contractor does not have current NCQA accreditation, including Medicaid, a partial audit, as defined by NCQA, must be conducted.

6.2.3. If the Contractor has current NCQA accreditation, including Medicaid, the Contractor may rotate HEDIS(R) measures in accord with the most current requirements for the HEDIS(R) rotation strategy published by NCQA. If the Contractor does not have current NCQA accreditation, including Medicaid, the Contractor may not rotate measures, unless directed otherwise in writing by DSHS.

6.3. ENCOUNTER DATA:

6.2.1. The Contractor shall comply with the Encounter Data Submission Requirements, Exhibit C-1.

6.2.2. DSHS may change the Encounter Data Submission Requirements, Exhibit C-1, with one hundred and fifty (150) calendar days written notice to the Contractor. The Contractor shall, upon receipt of such notice from DSHS, provide notice of changes to subcontractors.

6.2.3. The Contractor shall correct rejected encounter data and resubmit within the timelines specified in the Encounter Data Submission Requirements, Exhibit C-1.

6.2.4. The Contractor shall correct errors indicated in each DSHS encounter data error report in succeeding submissions in accord with the Encounter Data Submission Requirements, Exhibit C-1.

6.2.5. The Contractor may request that DSHS waive reporting requirements. Such request shall be in writing and shall be approved at the sole discretion of DSHS. DSHS also reserves the right to waive data reporting requirements under exceptional circumstances. Any waiver shall be in writing.

6.4. INTEGRATED PROVIDER NETWORK DATABASE (IPND):

6.4.1. The Contractor shall provide monthly provider network reports to the designated data management contact in accord with the Provider Network Reporting Requirements, Exhibit C-2 (a).

6.4.2. DSHS will identify records that do not comply with the Provider Network Reporting Requirements in a monthly report to the Contractor. DSHS will identify records as being rejected or containing errors. Rejected records will not appear in the Integrated Provider Network Database (IPND) for that month.

6.4.3. The Contractor shall review records identified on the reject and error reports, and make corrections for subsequent monthly submissions.

6.4.4. Failure to comply with the data submission schedule shall result in the implementation of the IPND Escalation Procedure, Exhibit C-2 (b).

6.5. MONTHLY ADJUSTMENT REPORT FOR FQHC/RHC ENROLLEES: The Contractor shall provide DSHS with a monthly report for enrollees enrolled with federally-qualified health centers (FQHC) and rural health clinics (RHC), in the format described in the DSHS Healthy Options Licensed Health Carrier Billing Instructions, published by DSHS.

6.6. ENROLLEE MORTALITY: The Contractor shall maintain a record of known enrollee deaths, including the enrollee's name, date of birth, age at death, location of death, and cause(s) of death. This information shall be available to DSHS upon request. The Contractor shall assist DSHS in efforts to evaluate and improve the availability and utility of selected mortality information for quality improvement purposes.

6.7. CAHPS(R): The contractor is required to conduct a CAHPS(R) survey of adult Medicaid members enrolled in Healthy Options. The Contractor shall:

6.7.1. Ensure the survey sample frame consists of all non-Medicare and non-commercial adult plan members (not just subscribers) 18 years and older, as of December 31 of the measurement year, with Washington State addresses.

6.7.2. Contract with an NCQA certified vendor qualified to administer the CAHPS(R) survey and conduct the survey according to NCQA protocol.

6.7.3. Contract with an NCQA-licensed organization to conduct a HEDIS(R) Compliance Audit for CAHPS(R) and submit the complete audit report to DSHS.

6.7.4. Use the most recent HEDIS(R) version of the Medicaid adult questionnaire (currently 2.0H) or as instructed by DSHS for 2003 CAHPS(R) surveys, and include the following questions in the survey instrument:

6.7.5. Adult supplemental "Behavioral Health" MH1&MH2

6.7.5.1. Adult supplemental "Chronic Conditions" CC2, CC6, CC7, CC11, CC12

6.7.5.2. Adult supplemental "Pregnancy Care" P1-P4

6.7.5.3. Adult supplemental "Prescription Medicine" PM1 & PM2

6.7.5.4. Family Centered Care - decisions

6.4.1. Conduct the mixed methodology (mail and phone surveys) in 2003.

6.7.6. Submit a copy of the Washington State adult Medicaid response data set according to NCQA/CAHPS(R) standards to DSHS' External Quality Review vendor by June 30, 2003.

6.7.7. DSHS' External Quality Review vendor will forward Health plan data to the National CAHPS(R) Benchmarking Database (NCBD) based on the 2003 NCBD guidelines. Contractors will be responsible for filling out specific NCBD data submission forms as determined by DSHS.

6.8. DENIALS, COMPLAINTS AND APPEALS:

The Contractor shall maintain a record of all denials, complaints and appeals, including denials, complaints and appeals handled by a delegated entity and independent review of adverse decisions by an independent review organization. The Contractor shall provide a report of complete denials, complaints and appeals to DSHS quarterly within sixty (60) calendar days of the end of the quarter. Delegated denials, complaints and appeals are to be integrated into the Contractor's report. DSHS and Contractor agree to collaborate in the development of a report format. The report medium shall be specified by DSHS. Reporting of denials shall include all denials of services to enrollees. The records shall be sorted using the sort keys identified and shall include, at a minimum:

6.8.1. Name of Program: HO, HO-CSHCN, CHIP, CHIP-CSHCN, BH+, or BH+-CSHCN (Primary Sort Key)

6.8.2. Name of the delegated entity, if any

6.8.3. Enrollee Identifier (three separate fields):

6.8.3.1. Patient Identification Code (PIC) (preferred) or

6.8.3.2. Enrollee Name and Enrollee Birthday: If PIC not reported

6.8.4. Name of Practitioner

6.8.5. Type of Practitioner (Optional)

6.8.6. Type (Secondary Sort Key):

6.8.6.1. Denial

6.8.6.2. Complaint

6.8.6.3. Appeal - First Level

6.8.6.4. Appeal - Second Level

6.8.6.5. IRO

6.8.7. Expedited: Yes or No

6.8.8. Complaint, Appeal or IRO Issue

6.8.9. Category of Service Denied

6.8.10. Reason Service Denied

6.8.11. Resolution of Complaint, Appeal or IRO

6.8.12. Denial Date

6.8.13. Receipt Date of Complaint, Appeal or IRO

6.8.14. Date of Resolution of Complaint, Appeal, or IRO

6.8.15. Date written notification of Denial or Complaint, Appeal or IRO outcome sent to enrollee and practitioner

6.9. DRUG FORMULARY REVIEW AND APPROVAL: The Contractor shall submit its drug formulary, for use with enrollees covered under the terms of this agreement, to DSHS for review and approval by January 31, 2003.

6.10. FRAUD AND ABUSE: The Contractor shall report in writing all verified cases of fraud and abuse, including fraud and abuse by the Contractor's employees and subcontractors, within seven (7) calendar days to DSHS according to Section 7.5, Notices. The report shall include the following information:

6.10.1. Subject(s) of complaint by name and either provider/subcontractor type or employee position.

6.10.2. Source of complaint by name and provider/subcontractor type or employee position, if applicable.

6.10.3. Nature of complaint.

6.10.4. Estimate of the amount of funds involved.

6.10.5. Legal and administrative disposition of case.

6.11. FIVE PERCENT EQUITY: The Contractor shall provide the DSHS, MAA, Division of Program Support, Contract Manager assigned to the Contractor a list of persons with a beneficial ownership of more than 5% of the Contractor's equity no later than February 28, 2003.

7. GENERAL TERMS AND CONDITIONS

7.1. COMPLETE AGREEMENT: This agreement incorporates Exhibits to this agreement and the DSHS billing instructions applicable to the Contractor. All terms and conditions of this agreement are stated in this agreement and its incorporations. No other agreements, oral or written, are binding.

7.2. MODIFICATION: This agreement may only be modified by mutual consent of the parties. All modifications shall be set forth in contract amendments issued by DSHS.

7.3. WAIVER: The failure of either party to enforce any provision of this agreement shall not constitute a waiver of that or any other provision, and shall not be construed to be a modification of the terms and conditions of the agreement unless incorporated into the agreement with an amendment.

7.4. LIMITATION OF AUTHORITY: No alteration, modification, or waiver of any clause or condition of the agreement is binding unless made in writing and signed by a DSHS Contracting Officer in the Office of Legal Affairs, Central Contract Services.

7.5. NOTICES: Whenever one party is required to give notice to the other under this agreement, it shall be deemed given if mailed by United States Postal Service, registered or certified mail, return receipt requested, postage prepaid and addressed as follows:

In the case of notice to the Contractor:

____
____
____
____

In the case of notice to DSHS:

MaryAnne Lindeblad, Director (or her successor)
Division of Program Support
Medical Assistance Administration
Department of Social and Health Services
P.O. Box 45530

Olympia, WA 98504-5530

Said notice shall become effective on the date delivered as evidenced by the return receipt or the date returned to the sender for non-delivery other than for insufficient postage. Either party may at any time change its address for notification purposes by mailing as aforesaid a notice stating the change and setting forth the new address, which shall be effective on the tenth day following the effective date of such notice unless a later date is specified.

7.6. FORCE MAJEURE: If the Contractor is prevented from performing any of its obligations hereunder in whole or in part as a result of a major epidemic, act of God, war, civil disturbance, court order, or any other cause beyond its control, such nonperformance shall not be a ground for termination for default. Immediately upon the occurrence of any such event, the Contractor shall commence to use its best efforts to provide, directly or indirectly, alternate and, to the extent practicable, comparable performance. Nothing in this clause shall be construed to prevent DSHS from terminating this agreement for reasons other than for default during the period of events set forth above, or for default, if such default occurred prior to such event.

7.7. SANCTIONS:

7.7.1. When the Contractor fails to meet its obligations under the terms of this agreement, DSHS may impose sanctions by withholding up to five percent of payments to the Contractor rather than terminating the agreement.

DSHS shall notify the Contractor in writing of the precise nature of the default and provide a reasonable deadline for curing the default before imposing sanctions. The Contractor may request a dispute resolution, as described in Section 7.23, Disputes, if the Contractor disagrees with DSHS' position. DSHS may withhold payment from the end the cure period until the default is cured or any resulting dispute is resolved in the Contractor's favor.

7.7.2. DSHS, CMS or the Office of the Inspector General (OIG) may impose intermediate sanctions, in accord with 42 CFR 438.700, 42 CFR 438.702 and 42 CFR 438.704, against the Contractor for:

7.7.2.1. Failing to provide medically necessary services that the Contractor is required to provide, under law or under this agreement, to an enrollee covered under this agreement.

7.7.2.2. Imposing on enrollees premiums or charges that are in excess of the premiums or charges permitted under law or under this agreement.

7.7.2.3. Acting to discriminate among enrollees on the basis of their health status or need for health care services. This includes termination of enrollment or refusal to reenroll a recipient, except as permitted under law or under this agreement, or any practice that would reasonably be expected to discourage enrollment by recipients whose medical condition or history indicates probable need for substantial future medical services.

7.7.2.4. Misrepresenting or falsifying information that it furnishes to CMS or to the State.

7.7.2.5. Misrepresenting or falsifying information that it furnishes to an enrollee, potential enrollee, or health care provider.

7.7.2.6. Failing to comply with the requirements for physician incentive plans.

7.7.2.7. Distributing directly, or indirectly through any agent or independent contractor, marketing materials that have not been approved by the State or that contain false or materially misleading information.

7.7.2.8. Violating any of the other requirements of sections 1903(m) or 1932 of the Social Security Act, and any implementing regulations.

7.8. ASSIGNMENT OF THIS AGREEMENT: This agreement, including the rights, benefits, and duties herein, shall be binding on the parties and their successors and assignees but shall not be assignable by either party without the express written consent of the other. Nor shall any claim, pertinent to this agreement, against one of the parties be assignable without the express written consent of the other.

7.9. HEADINGS NOT CONTROLLING: The headings and the index used herein are for reference and convenience only, and shall not enter into the interpretation thereof, or describe the scope or intent of any provisions or sections of this agreement.

7.10. ORDER OF PRECEDENCE: In the interpretation of this agreement and incorporated documents, the various terms and conditions shall be construed as much as possible to be complementary. In the event that such interpretation is not possible the following order of precedence shall apply:

7.10.1. Federal statutes and regulations concerning the operation of Health Maintenance Organizations and the provisions of Title XIX of the federal Social Security Act.

7.10.2. State of Washington statutes and regulations concerning the operation of the DSHS' Medical Assistance Program, including but not limited to WAC 388-538, Exhibit B.

7.10.3. State of Washington statutes and regulations concerning the operation of Health Maintenance Organizations and Health Care Service Contractors.

7.10.4. The terms and conditions of this agreement.

7.11. PROPRIETARY RIGHTS: DSHS recognizes that nothing in this agreement shall give DSHS rights to the systems developed or acquired by the Contractor during the performance of this agreement. The Contractor recognizes that nothing in this agreement shall give the Contractor rights to the systems developed or acquired by DSHS during the performance of this agreement.

7.12. COVENANT AGAINST CONTINGENT FEES: The Contractor promises that no person or agency has been employed or retained on a contingent fee for the purpose of seeking or obtaining this agreement. This does not apply to legitimate employees or an established commercial or selling agency maintained by the Contractor for the purpose of securing business. In the event of breach of this clause by the Contractor DSHS may at its discretion: a) annul the agreement without any liability; or b) deduct from the agreement price or consideration or otherwise recover the full amount of any such contingent fee.

7.13. ENROLLEES' RIGHT TO OBTAIN A CONVERSION AGREEMENT: The Contractor shall offer a conversion agreement to all enrollees whose enrollment is terminated due to loss of eligibility for Medical Assistance in accord with RCW 48.46.450.

7.14. RECORDS MAINTENANCE AND RETENTION:

7.14.1. MAINTENANCE: The Contractor and its subcontractors shall maintain financial, medical and other records pertinent to this agreement. All financial records shall follow generally accepted accounting principles. Medical records and supporting management systems shall include all pertinent information related to the medical management of each enrollee. Other records shall be maintained as necessary to clearly reflect all actions taken by the Contractor related to this agreement.

7.14.2. RETENTION: All records and reports relating to this agreement shall be retained by the Contractor and its subcontractors for a minimum of six (6) years after final payment is made under this agreement or, in the event that this agreement is renewed, six (6) years after the renewal date. However, when an audit, litigation, or other action involving

records is initiated prior to the end of said period, records shall be maintained for a minimum of six (6) years following resolution of such action.

7.15. ACCESS TO FACILITIES AND RECORDS: The Contractor and its subcontractors shall cooperate with medical and financial audits performed by duly authorized representatives of DSHS, the State of Washington Auditor's Office, DHHS, and federal auditors from the United States government General Accounting Office and the Office of Management and Budget. With reasonable notice, generally thirty (30) calendar days, the Contractor and its subcontractors shall provide access to its facilities and the financial and medical records pertinent to this agreement to monitor and evaluate performance under this agreement, including, but not limited to, the quality, cost, use and timeliness of services (42 CFR 434.52), and assessment of the Contractor's capacity to bear the potential financial losses (42 CFR 434.58). The Contractor and its subcontractors shall provide immediate access to facilities and records pertinent to this agreement for Medicaid fraud investigators.

7.16. SOLVENCY:

7.16.1. The Contractor shall have a Certificate of Registration as either a Health Maintenance Organization or a Health Care Service Contractor from the Office of the Insurance Commissioner (OIC). The Contractor shall comply with the solvency provisions of RCW 48.44 or RCW 48.46, as amended.

7.16.2. The Contractor shall submit to DSHS copies of any regulatory annual statement and any quarterly or monthly financial reports filed with OIC and all related documents and correspondence, at the same time the Contractor sends them to OIC. The Contractor shall notify DSHS immediately upon being notified by OIC that they are to report financial information quarterly or monthly and provide DSHS with the same information provided to OIC in response to any OIC request. The Contractor shall deliver all required information and notices to DSHS at the address listed in 7.5 Notices. The Contractor agrees that DSHS may at anytime access any information related to the Contractor's financial condition, or compliance with OIC requirements, from OIC and consult with OIC concerning such information.

7.16.3. The Contractor shall provide DSHS with the Contractor's audited financial statements as soon as they become available to the Contractor. Financial statements shall be delivered to the address list in 7.5 Notices.

7.16.4. If the Contractor becomes insolvent during the term of this agreement:

7.16.4.1. The State of Washington and enrollees shall not be in any manner liable for the debts and obligations of the Contractor.

7.16.4.2. In accordance with Section 10.15 Prohibition on Enrollee Charges for Covered Services, under no circumstances shall the Contractor, or any providers used to deliver services covered under the terms of this agreement, charge enrollees for covered services.

7.16.4.3. The Contractor shall, in accordance with RCW 48.44.055, provide for the continuity of care for enrollees.

7.17. COMPLIANCE WITH ALL APPLICABLE LAWS AND REGULATIONS: In the provision of services under this agreement, the Contractor and its subcontractors shall comply with all applicable federal and state statutes and regulations, and all amendments thereto, that are in effect when the agreement is signed or that come into effect during the term of the agreement. This includes, but is not limited to:

7.17.1. Title XIX and Title XXI of the Social Security Act.

7.17.2. All applicable OIC statutes and regulations.

7.17.3. All local, state, and federal professional and facility licensing and accreditation requirements/standards that apply to services performed under the terms of this agreement, including but not limited to:

7.17.3.1. All applicable standards, orders, or requirements issued under Section 306 of the Clean Air Act (42 US 1857(h)), Section 508 of the Clean Water Act (33 US 1368), Executive Order 11738, and Environmental Protection Agency (EPA) regulations (40 CFR Part 15), which prohibit the use of facilities included on the EPA List of Violating Facilities. Any violations shall be reported to DSHS, DHHS, and the EPA.

7.17.3.2. Any applicable mandatory standards and policies relating to energy efficiency which are contained in the State Energy Conservation Plan, issued in compliance with the federal Energy Policy and Conservation Act.

7.17.3.3. Those specified for laboratory services in the Clinical Laboratory Improvement Amendments (CLIA).

7.17.3.4. Those specified in Title 18 for professional licensing.

7.17.4. Liability insurance requirements.

7.17.5. Reporting of abuse as required by RCW 26.44.030.

7.17.6. Industrial insurance coverage as required by Title 51 RCW.

7.17.7. Any other requirements associated with the receipt of federal funds.

7.18. NONDISCRIMINATION: The Contractor shall comply with all federal and state nondiscrimination laws and regulations.

7.19. REVIEW OF CLIENT INFORMATION: DSHS agrees to provide the Contractor with written client information, which DSHS intends to distribute to all or a class of clients.

7.20. CONTRACTOR NOT EMPLOYEES OF DSHS: The Contractor acknowledges and certifies that its directors, officers, partners, employees, and agents are not officers, employees, or agents of DSHS or the state of Washington. The Contractor shall not hold itself out as or claim to be an officer, employee, or agent of DSHS or the state of Washington by reason of this agreement. The Contractor shall not claim any rights, privileges, or benefits that would accrue to a civil service employee under RCW 41.06.

7.21. DSHS NOT GUARANTOR: The Contractor acknowledges and certifies that neither DSHS nor the State of Washington are guarantors of any obligations or debts of the Contractor.

7.22. MUTUAL INDEMNIFICATION AND HOLD HARMLESS: The parties shall be responsible for and shall indemnify and hold each other harmless from all claims and/or damages to persons and/or property resulting from its negligent acts and omissions. The Contractor shall indemnify and hold harmless DSHS from any claims by non-participating providers related to the provision to enrollees of covered services under this agreement.

7.23. DISPUTES: When a dispute arises over an issue concerning the terms of the agreement, the parties agree to the following process to address the dispute:

7.23.1. The Contractor and DSHS shall attempt to resolve the dispute through informal means between the Contractor and the DSHS, MAA, Division of Program Support, Contract Manager assigned to the Contractor.

7.23.2. If the Contractor is not satisfied with the outcome of the resolution with the Contract Manager, the Contractor may submit the disputed issue, in writing, for review, within ten (10) working days of the outcome, to:

MaryAnne Lindeblad, Director (or her successor)
Division of Program Support

Medical Assistance Administration
Department of Social and Health Services
P.O. Box 45530
Olympia, WA 98504-5530

The Director may request additional information from the Contract Manager and/or the Contractor. The Director shall issue a written review decision to the Contractor within thirty (30) calendar days of receipt of all information relevant to the issue. The review decision will be provided to the Contractor according to Section 7.5.

7.23.3. When the Contractor disagrees with the review decision of the Director, the Contractor may request independent mediation of the dispute. The request for mediation must be submitted to the Director, in writing, within ten (10) working days of the Contractor's receipt of the Director's review decision. The Contractor and DSHS shall mutually agree on the selection of the independent mediator and shall bear all costs associated with mediation equally. The results of mediation shall not be binding on either party.

Both parties agree to make their best efforts to resolve disputes arising from this agreement and agree that the dispute resolution process described herein shall precede any court action. This dispute resolution process is the sole administrative remedy available under this agreement.

7.24. GOVERNING LAW AND VENUE: The laws of the State of Washington shall govern this agreement. In the event of a lawsuit involving this agreement, venue shall be proper only in Thurston County, Washington. By execution of this agreement, the Contractor acknowledges the jurisdiction of the courts of the State of Washington regarding this matter.

7.25. SEVERABILITY: If any provision of this agreement, including any provision of any document incorporated by reference, shall be held invalid, that invalidity shall not affect the other provisions of the agreement. To that end, the provisions of this agreement are declared to be severable.

7.26. EXCLUDED PERSONS:

7.26.1. The Contractor may not knowingly have a director, officer, partner, or person with a beneficial ownership of more than 5% of the Contractor's equity, or have an employee, consultant or contractor who is significant or material to the provision of services under this agreement, who has been, or is affiliated with someone who has been, debarred, suspended, or otherwise excluded by any federal agency (SSA 1932(d)(1)). A list of excluded parties is available on the following Internet website: www.arnet.gov/epls.

7.26.2. By entering into this agreement, the Contractor certifies that it does not knowingly have anyone who is an excluded person, or is affiliated with an excluded person, as a director, officer, partner, employee, contractor, or person with a beneficial ownership of more than 5% of its equity. The Contractor is required to notify DSHS when circumstances change that affect such certification.

7.26.3. The Contractor is not required to consult the excluded parties list, but may instead rely on certifications from directors, officers, partners, employees, contractors, or persons with beneficial ownership of more than 5% of the Contractor's equity, that they are not debarred or excluded from a federal program.

7.27. FRAUD AND ABUSE REQUIREMENTS - POLICIES AND PROCEDURES:

7.27.1. The Contractor shall have policies and procedures to prevent and detect fraud and abuse activities related to Healthy Options/SCHIP. These include, but are not limited to: claims, prior authorization, utilization management and quality review, enrollee complaint and grievance resolution, provider credentialing and contracting, and provider and staff education to prevent fraud and abuse, and corrective action plans to remedy situations where fraud and abuse have been detected.

7.27.2. If the Contractor is also a Medicare contractor, and if CMS has promulgated fraud and abuse standards for federal health care program managed care contractors, the Contractor's policies and procedures established which meet CMS standards shall be deemed sufficient to meet DSHS requirements for fraud and abuse prevention and monitoring.

7.27.3. The Contractor shall submit a written copy of its fraud and abuse policies and procedures for approval to DSHS according to Section 7.5, Notices. Policies and procedures shall be due by March 31, 2003. DSHS shall respond with approval or denial with required modifications within thirty (30) calendar days of receipt. The Contractor shall have thirty (30) calendar days to resubmit the policies and procedures. If the Contractor's fraud and abuse policies and procedures have been approved by DSHS and are unchanged from the approved policies and procedures, the Contractor shall only be required to submit a written certification that the policies and procedures are unchanged.

7.27.4. The Contractor may request a copy of the guidelines that DSHS will use in evaluating the Contractor's fraud and abuse policies and procedures, and may request technical assistance in preparing the

policies and procedures, by contacting the DSHS, MAA, Division of Program Support Contract Manager assigned to the Contractor.

8. SUBCONTRACTS

8.1. CONTRACTOR REMAINS LEGALLY RESPONSIBLE: Subcontracts, as defined in Section 1.20, may be used by the Contractor for the provision of any service under this agreement. However, no subcontract shall terminate the Contractor's legal responsibility to DSHS for any work performed under this agreement (42 CFR 434.6 (c)).

8.2. SOLVENCY REQUIREMENTS FOR SUBCONTRACTORS: For any subcontractor at financial risk, as described in Section 8.8.3. Substantial Financial Risk, or 1.17. Risk, the Contractor shall establish, enforce and monitor solvency requirements that provide assurance of the subcontractor's ability to meet its obligations.

8.3. REQUIRED PROVISIONS: Subcontracts must be in writing, consistent with the provisions of 42 CFR 434.6. All subcontracts must contain the following provisions:

8.3.1. Identification of the parties of the subcontract and their legal basis for operation in the state of Washington.

8.3.2. Procedures and specific criteria for terminating the subcontract.

8.3.3. Identification of the services to be performed by the subcontractor and which of those services may be subcontracted by the subcontractor.

8.3.4. Reimbursement rates and procedures for services provided under the subcontract.

8.3.5. Release to the Contractor of any information necessary to perform any of its obligations under this agreement.

8.3.6. Reasonable access to facilities and financial and medical records for duly authorized representatives of DSHS or DHHS for audit purposes, and immediate access for Medicaid fraud investigators.

8.3.7. The requirement to completely and accurately report encounter data to the Contractor. Contractor shall ensure that all subcontractors required to report encounter data have the capacity to comply with the Encounter Data Submission Requirements, Exhibit C-1.

8.3.8. The requirement to comply with the Contractor's DSHS approved fraud and abuse policies and procedures.

8.3.9. No assignment of the subcontract shall take effect without the DSHS' written agreement.

8.3.10. The subcontractor must comply with the applicable state and federal rules and regulations as set forth in this agreement.

8.4. HEALTH CARE PROVIDER SUBCONTRACTS, including those for facilities, must also contain the following provisions:

8.4.1. A quality improvement system tailored to the nature and type of services subcontracted, which affords quality control for the health care provided, including but not limited to the accessibility of medically necessary health care, and which provides for a free exchange of information with the Contractor to assist the Contractor in complying with Section 5.1.

8.4.2. A means to keep records necessary to adequately document services provided to enrollees.

8.4.3. Information about enrollees, including their medical records, shall be kept confidential in a manner consistent with state and federal laws and regulations.

8.4.4. The subcontractor accepts payment from the Contractor as payment in full and shall not request payment from DSHS or any enrollee for covered services performed under the subcontract.

8.4.5. The subcontractor agrees to hold harmless DSHS and its employees, and all enrollees served under the terms of this agreement in the event of non-payment by the Contractor. The subcontractor further agrees to indemnify and hold harmless DSHS and its employees against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may in any manner accrue against DSHS or its employees through the intentional misconduct, negligence, or omission of the subcontractor, its agents, officers, employees or contractors.

8.4.6. If the subcontract includes physician services, provisions for compliance with the PCP requirements stated in this agreement.

8.4.7. A ninety (90) day termination notice provision.

8.4.8. A specific termination provision for termination with short notice when a provider is excluded from participation in the Medicaid program.

8.5. HEALTH CARE PROVIDER SUBCONTRACTS DELEGATING ADMINISTRATIVE FUNCTIONS: Subcontracts that delegate administrative functions under the terms of this agreement must include the following additional provisions:

8.5.1. For those subcontractors at financial risk, that the subcontractor must maintain the Contractor's solvency requirements throughout the term of the agreement.

8.5.2. That the terms and conditions of this agreement, between DSHS and the Contractor, apply to the subcontractor for any contract responsibility the Contractor has delegated in the subcontract.

8.5.3. Clear descriptions of any administrative functions delegated by the Contractor in the subcontract, including but not limited to utilization/medical management, claims processing, enrollee complaints and appeals, and the provision of data or information necessary to fulfill any of the Contractor's obligations under this agreement.

8.5.4. How frequently and by what means the Contractor will monitor compliance with solvency requirements and requirements related to any administrative function delegated in the subcontract.

8.5.5. Whether referrals for enrollees will be restricted to providers affiliated with the group and, if so, a description of those restrictions.

8.6. EXCLUDED PROVIDERS:

8.6.1. Pursuant to Section 1128 of the Social Security Act, the Contractor may not subcontract with an individual practitioner or provider, or an entity with an officer, director, agent, or manager, or an individual who owns or has a controlling interest in the entity, who has been: convicted of crimes as specified in Section 1128 of the Social Security Act, excluded from participation in the Medicare and Medicaid program, assessed a civil penalty under the provisions of Section 1128, has a contractual relationship with an entity convicted of a crime specified in Section 1128, or is a person described in Section 7.26 of this agreement, Excluded Persons.

8.6.2. In addition, if DSHS terminates a subcontractor from participation in the Medical Assistance program, the Contractor shall exclude the subcontractor from participation in Healthy Options/SCHIP. The Contractor shall terminate subcontracts of excluded providers immediately when the Contractor becomes aware of such exclusion or when the Contractor receives notice from DSHS, whichever is earlier.

8.7. HOME HEALTH PROVIDERS: If the pending Medicaid home health agency surety bond requirement (Section 4708(d) of the Balanced Budget Act of 1997) becomes effective before or during the term of this agreement, beginning on the effective date of the requirement the Contractor may not subcontract with a home health agency unless the state has obtained a surety bond from the home health agency in the amount required by federal law. The Department will provide a current list of bonded home health agencies upon request to the Contractor.

8.8. PHYSICIAN INCENTIVE PLANS: Physician incentive plans, as defined in Section 1.15, are subject to the conditions set forth in this Section in accord with federal regulations (42 CFR 434.70).

8.8.1. PROHIBITED PAYMENTS: The Contractor shall make no payment to a physician or physician group, directly or indirectly, under a physician incentive plan as an inducement to reduce or limit medically necessary services provided to an individual enrollee.

8.8.2. DISCLOSURE REQUIREMENTS: Risk sharing arrangements in subcontracts with physicians or physician groups are subject to review and approval by DSHS. The Contractor shall provide the following information about its physician incentive plan, and the physician incentive plans of all its subcontractors in any tier, to the Department annually upon request:

8.8.2.1. Whether the incentive plan includes referral services.

8.8.2.2. If the incentive plan includes referral services:

8.8.2.2.1. The type of incentive plan (e.g. withhold, bonus, capitation)

8.8.2.2.2. For incentive plans involving withholds or bonuses, the percent that is withheld or paid as a bonus

8.8.2.2.3. Proof that stop-loss protection meets the requirements of 6.8.4.1., including the amount and type of stop-loss protection

8.8.2.2.4. The panel size and, if commercial members and enrollees are pooled, a description of the groups pooled and the risk terms of each group. Medicaid, Medicare, and commercial members in a physician's or physician group's panel may be pooled provided the terms of risk for the pooled enrollees and commercial members are comparable, and the incentive payments are not calculated separately for pooled enrollees. Commercial members include military and Basic Health Plan members.

8.8.3. SUBSTANTIAL FINANCIAL RISK: A physician, or physician group as defined in Section 1.14, is at substantial financial risk when more than 25% of the total maximum potential payments to the physician or physician group depend on the use of referral services. When the panel size is fewer than 25,000 members arrangements that cause substantial financial risk include, but are not limited to, the following:

8.8.3.1. Withholds greater than 25% of total potential payments

8.8.3.2. Withholds less than 25% of total potential payments but the physician or physician group is potentially liable for more than 25% of total potential payments.

8.8.3.3. Bonuses greater than 33% of total potential payments, less the bonus.

8.8.3.4. Withholds plus bonuses if the withholds plus bonuses equal more than 25% of total potential payments.

8.8.3.5. Capitation arrangements if the difference between the minimum and maximum possible payments is more than 25% of the maximum possible payments, or the minimum and maximum possible payments are not clearly explained in the contract.

8.8.4. REQUIREMENTS IF A PHYSICIAN OR PHYSICIAN GROUP IS AT SUBSTANTIAL FINANCIAL RISK: If the Contractor, or any subcontractor (e.g. IPA, PHO), places a physician or physician group at substantial financial risk, the Contractor shall assure that all physicians and physician groups have either aggregate or per member stop-loss protection for services not directly provided by the physician or physician group.

8.8.4.1. If aggregate stop-loss protection is provided, it must cover 90% of the costs of referral services that exceed 25% of maximum potential payments under the subcontract.

8.8.4.2. If stop-loss protection is based on a per-member limit, it must cover 90% of the cost of referral services that exceed the limit as indicated below based on panel size, and whether stop-loss is provided separately for professional and institutional services or is combined for the two.

8.8.4.2.1. 1,000 members or fewer, the threshold is $3,000 for professional services and $10,000 for institutional services, or $6,000 for combined services.

8.8.4.2.2. 1,001 - 5,000 members, the threshold is $10,000 for professional services and $40,000 for institutional services, or $30,000 for combined services.

8.8.4.2.3. 5,001 - 8,000 members, the threshold is $15,000 for professional services and $60,000 for institutional services, or $40,000 for combined services.

8.8.4.2.4. 8,001 - 10,000 members, the threshold is $20,000 for professional services and $100,000 for institutional services, or $75,000 for combined services.

8.8.4.2.5. 10,001 - 25,000, the threshold is $25,000 for professional services and $200,000 for institutional services, or $150,000 for combined services.

8.8.4.2.6. 25,001 members or more, there is no risk threshold.

8.8.4.3. For a physician or physician group at substantial financial risk, the Contractor shall periodically conduct surveys of enrollee satisfaction with the physician or physician group. DSHS shall require such surveys annually. DSHS may, at its sole option, conduct enrollee satisfaction surveys which satisfy this requirement and waive the requirement for the Contractor to conduct such surveys. DSHS shall notify the Contractor in writing if the requirement is waived. If DSHS does not waive the requirement, the Contractor shall provide the survey results to DSHS annually upon request. The surveys shall:

8.8.4.3.1. Include current enrollees, and enrollees who have disenrolled within 12 months of the survey for reasons other than loss of Medicaid eligibility or moving outside the Contractor's service area.

8.8.4.3.2. Be conducted according to commonly accepted principles of survey design and statistical analysis.

8.8.4.3.3. Address enrollees satisfaction with the physician or physician group's:

8.8.4.3.3.1. Quality of services provided.

8.8.4.3.3.2. Degree of access to services.

8.8.5. Sanctions and Penalties: DSHS or CMS may impose intermediate sanctions, as described in Section 7.7 of this agreement, for failure to comply with the rules in this section.

8.9. Payment to FQHCs/RHCs: The Contractor shall not pay a federally qualified health center or a rural health clinic less than the Contractor would pay non-FQHC/RHC providers for the same services (42 USC 1396(m)(2)(A)(ix)).

9. TERM AND TERMINATION

9.1. TERM: This agreement is effective from January 1, 2003 at 12:01 a.m. Pacific Standard Time (PST) through 12:00 a.m. December 31, 2003, PST. This agreement may be extended by mutual agreement of the parties.

9.2. TERMINATION FOR CONVENIENCE:

9.2.1. Either party may terminate, upon one-hundred twenty (120) calendar days advance written notice, performance of work under this agreement in whole or in part, whenever, for any reason, either party shall determine that such termination is in its best interest.

9.2.2. In the event DSHS terminates this agreement for convenience, the Contractor shall have the right to assert a claim for the Contractor's direct termination costs. Such claim must be:

9.2.2.1. Delivered to DSHS as provided in section 7.5., Notices.

9.2.2.2. Asserted within ninety (90) calendar days of termination for convenience, or, in the event the termination was originally issued under the provisions of Section 9.3, Termination by DSHS for Default, ninety (90) calendar days from the date the notice of termination was deemed to have been issued under this section. The Contracts Coordination Unit of MAA (CCU) may extend said ninety (90) calendar days if the Contractor makes a written request to the CCU and CCU deems the grounds for the request to be reasonable. The CCU will evaluate the claim for termination costs and order DSHS to pay the claim or such amount, as s/he deems valid, or deny the claim. The CCU shall notify the Contractor of CCU's decision within sixty (60) calendar days of receipt of the claim.

9.2.3. In the event the Contractor terminates this agreement for convenience, DSHS shall have the right to assert a claim for DSHS' direct termination costs. Such claim must be:

9.2.3.1. Delivered to the Contractor as provided in section 7.5., Notices.

9.2.3.2. Asserted within ninety (90) calendar days of the date of termination for convenience. The CCU may extend said ninety (90) calendar days if DSHS makes a written request to the CCU and CCU deems the grounds for the request to be reasonable. The CCU will evaluate the claim for termination costs and order the Contractor to pay the claim for such amount, as CCU deems valid, or deny the claim.

9.2.4. In the event the Contractor or DSHS disagrees with the CCU decision entered pursuant to this section, the Contractor or DSHS shall have the right to a dispute resolution as described in Section 7.23, Disputes.

9.2.5. In no event shall the claim for termination costs exceed the average monthly amount paid to the Contractor for the twelve (12) months immediately prior to termination.

9.2.6. In addition to DSHS' or Contractor's direct termination costs, the Contractor or DSHS shall be liable for administrative costs incurred by the other party in procuring supplies or services similar to and/or replacing those terminated.

9.2.7. The Contractor or DSHS shall not be liable for any termination costs if it notifies the other party of its intent not to renew this agreement at least one hundred twenty (120) calendar days prior to the renewal date.

9.2.8. In the event this agreement is terminated for the convenience of either party, the effective date of termination must be the last day of the month in which the one hundred twenty (120) day notification period is satisfied, or the last day of such later month as may be agreed upon by both parties.

9.3. TERMINATION BY THE CONTRACTOR FOR DEFAULT: The Contractor may terminate its performance under this agreement in whole or in part, whenever DSHS shall default in performance of this agreement and shall fail to cure such default within a period of one hundred twenty (120) calendar days (or such longer period as the Contractor may allow) after receipt from the Contractor of a written notice specifying the default. In the event it is determined that DSHS was not in default, DSHS may claim damages for wrongful termination. The procedure for determining damages shall be as stated in Section 9.2.

9.4. TERMINATION BY DSHS FOR DEFAULT:

9.4.1. DSHS may terminate performance of work under this agreement, in whole or in part, whenever the Contractor shall default in performance

of this agreement and shall fail to cure such default within a period of one hundred twenty (120) calendar days (or such longer period as the Contracting Officer may allow) after receipt from the Contracting Officer of a written notice specifying the default. Such termination shall be referred to herein as "Termination for Default."

9.4.2. If after notice of termination of this agreement for default it is determined by DSHS or a court of law that the Contractor was not in default or that the Contractor's failure to perform or make progress in performance was due to causes beyond the control and without the error or negligence of the Contractor, or any subcontractor, the Contractor may claim damages. The procedure for determining damages shall be as stated in Section 9.2.

9.4.3. In the event DSHS terminates this agreement as provided in (a) above, DSHS may procure, upon such terms and in such manner as the Contracting Officer may deem appropriate, supplies or services similar to those terminated, and if the Contractor is judged to be in default by a court of law, DSHS' damages shall be measured by any excess costs for such similar supplies or services. In addition, DSHS' damages may also include reasonable administrative costs incurred in procuring such similar supplies or services.

9.5. MANDATORY TERMINATION: DSHS will terminate this agreement in the event that the Secretary of DHHS determines that the Contractor does not meet the requirements for participation in the Medicaid program pursuant to Title XIX of the Social Security Act and all amendments.

In addition, DSHS is required under federal law to either impose temporary management or terminate this agreement if the Contractor is repeatedly found to not meet federal requirements for managed care Contractors, as specified in Section 1903(m) of the Social Security Act. Should this circumstance arise, DSHS will terminate this agreement consistent with Section 9.4, Termination by DSHS for Default.

9.6. TERMINATION FOR REDUCTION IN FUNDING: In the event funding from state, federal, or other sources is withdrawn, reduced or limited in any way after the effective date of this agreement and prior to the termination date, DSHS may terminate the agreement under the "Termination for Convenience" clause.

9.7. INFORMATION ON OUTSTANDING CLAIMS AT TERMINATION: In the event this agreement is terminated, the Contractor shall provide DSHS, within three hundred and sixty-five (365) calendar days, all available information reasonably necessary for the reimbursement of any outstanding claims for

services to enrollees (42 CFR 434.6(a)(6)). Information and reimbursement of such claims is subject to the provisions of Section 3, Payment.

9.8. CONTINUED RESPONSIBILITIES: After the termination of this agreement, the Contractor remains obligated to:

9.8.1. Cover hospitalized enrollees until discharge consistent with Section 3.7.

9.8.2. Submit reports required under Section 6.

9.8.3. Provide access to records as required in Section 7.15.

9.8.4. Provide the administrative services associated with covered services (e.g. claims processing, enrollee appeals) provided to enrollees under the terms of this agreement.

9.9. ENROLLEE NOTICE OF TERMINATION: DSHS shall inform enrollees when notice is given by either party of its intent to terminate this agreement as provided herein

10. SERVICE DELIVERY

10.1. SCOPE OF SERVICES: The Contractor shall cover enrollees for preventive care and diagnosis and treatment of illness and injury as set forth in Section 11, Schedule of Benefits. If a specific procedure or element of a covered service is covered by DSHS under its fee-for-service program as described in DSHS' billing instructions, the Contractor shall cover it subject to the specific exclusions and limitations in Section 11, Schedule of Benefits.

Except as specifically provided in Section 10.17, this shall not be construed to prevent the Contractor from establishing utilization control measures as it deems necessary to assure that services are appropriately utilized, provided that utilization control measures do not deny medically necessary covered services to enrollees. The Contractor may limit coverage of services to participating providers except as specifically provided in Section 4, Access and Capacity, Section 11, Schedule of Benefits, for emergency services, and as necessary to provide medically necessary services as described in 10.1.2.2., Urgent Services.

10.1.1. IN SERVICE AREA: In the service area, as defined in Section 2.1, the Contractor shall cover enrollees for all medically necessary services included in the scope of services covered by this agreement.

10.1.2. OUT OF SERVICE AREA:

10.1.2.1. EMERGENCY SERVICES: The Contractor shall cover emergency services and, follow-up care which is medically necessary before the enrollee's return to the service area, for enrollees temporarily outside of the service area, or who have moved to another service area but are still enrolled with the Contractor.

10.1.2.2. URGENT SERVICES: The Contractor shall cover urgent care that is medically necessary before the enrollee's return to the service area. Urgent care is associated with the presentation of medical signs that require immediate attention, but are not life threatening. The Contractor shall also cover follow-up care to urgent care when such care is medically necessary and cannot reasonably wait until the enrollee's return to the service area. Such services shall be provided for enrollees temporarily outside of the service area, or who have moved to another service area, but are still enrolled with the Contractor. The Contractor may require pre-authorization for urgent services as long as the wait times specified in Section 4.4, Appointment Standards, are not exceeded.

10.1.2.3. COVERAGE LIMITATION: When an enrollee moves out of a service area, or is temporarily staying with a parent or relative outside the service area, coverage shall be limited to ninety (90) calendar days beginning with the first of the month following the month in which the enrollee changes residence.

10.1.2.4. REFERRED SERVICES: If the Contractor, or a participating provider, refers an enrollee to a provider out of the service area to receive a covered service, the Contractor shall be responsible for the referred service.

10.2. MEDICAL NECESSITY DETERMINATION: The Contractor shall determine which services are medically necessary, according to utilization management requirements included in the Quality Improvement Program 2003 Standards, Exhibit A and according to the definition of Medically Necessary Services in Section 1.11 of this agreement. The Contractor's determination of medical necessity in specific instances shall be final except as specifically provided in sections 5.4, Enrollee Complaints and Appeals and 5.5, Fair Hearings.

10.3. ENROLLEE CHOICE OF PCP: The Contractor shall allow, to the extent possible and appropriate, each new enrollee to choose a participating PCP. In the case of newborns, the parent shall choose the newborn's PCP. If the enrollee does not make a choice at the time of enrollment, the Contractor shall assign the enrollee to a PCP or clinic, within reasonable proximity to the enrollee's home, no later than fifteen (15) working days after coverage begins. The Contractor shall allow an enrollee to change PCP or clinic at anytime with the change becoming effective no later than the beginning of the month following the enrollees request for the change (WAC 388-538-060, Exhibit B and WAC 284-43-251 (1)).

The Contractor shall allow children with special health care needs who utilize a specialist frequently to retain the specialist as a PCP, or alternatively, be allowed direct access to specialists for needed care.

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10.4. COORDINATION OF CARE: The Contractor shall ensure that health care services are coordinated for enrollees, in accordance with the provisions of the Quality Improvement Program 2003 Standards, Exhibit A, and as follows:

10.4.1. The Contractor shall ensure that PCPs are responsible for the provision, coordination, and supervision of health care to meet the needs of each enrollee, including initiation and coordination of referrals for medically necessary specialty care. The PCPs shall also be responsible for ongoing coordination with community health and social programs, including but not limited to First Steps Maternity Services and Maternity Case Management, and mental health services provided by the Regional Support Networks (RSN).

10.4.2. The Contractor shall ensure that PCPs develop individualized care plans for children with special health care needs, which ensure integration of clinical and non-clinical disciplines and services in the overall plan of care.

10.4.3. The Contractor shall provide or shall ensure practitioners provide case management of enrollees with chronic/high risk illnesses. These services include, but are not limited to, coordination of services for inpatient and outpatient care, and coordinated discharge planning. The Contractor shall provide support services to assist practitioners in providing such case management if it is not provided directly by the Contractor. The Contractor shall also provide or shall ensure PCPs provide ongoing coordination of community-based services required by enrollees, including but not limited to: First Steps Maternity Services and Maternity Case Management, Transportation, Regional Support Networks for mental health services, developmental disability services, local health departments, Title V services, home and community services for older and physically disabled individuals, alcohol and substance abuse services, and services for children with special health care needs. The Contractor shall provide support services to assist PCPs in providing such coordination of it is not provided directly by the Contractor.

10.5. SECOND OPINIONS: The Contractor shall allow enrollees a second opinion with any primary or specialty care physician who is participating with the Contractor when an enrollee wants additional information regarding treatment or believes the Contractor is not authorizing medically necessary care. At the Contractor's discretion, a clinically appropriate non-participating provider who is agreed upon by the Contractor and the enrollee may provide the second opinion.

This Section shall not be construed to require the Contractor to cover unlimited second opinions, nor to require the Contractor to cover any services other than the professional services of the second opinion provider.

10.6. ENROLLEE SELF-DETERMINATION: The Contractor shall ensure that all providers: obtain informed consent prior to treatment from enrollees, or persons authorized to consent on behalf of an enrollee as described in RCW 7.70.065; comply with the provisions of the Natural Death Act (RCW 70.122) and state and federal Medicaid rules concerning advance directives (WAC 388-501-0125 & 42 CFR 438.6); and, when appropriate, inform enrollees of their right to make anatomical gifts (RCW 68.50.540).

10.7. COMPLIANCE WITH FEDERAL REGULATIONS FOR STERILIZATIONS AND HYSTERECTOMIES: The Contractor shall assure that all sterilizations and hysterectomies performed under this agreement are in compliance with 42 CFR 441 Subpart F, and that the DSHS Sterilization Consent Form (DSHS 13-364(x)) or its equivalent is used.

10.8. PROGRAM INFORMATION: At the Contractor's request, DSHS shall provide the Contractor with pertinent documents including statutes, regulations, and current versions of billing instructions and other written documents which describe DSHS policies and guidelines related to service coverage and reimbursement.

10.9. CONFIDENTIALITY OF ENROLLEE INFORMATION: The Contractor shall comply with all state and federal laws and regulations concerning the confidentiality of enrollee information.

10.9.1. The use or disclosure of any information concerning an enrollee, including but not limited to medical records, by the Contractor and its subcontractors for any purpose not directly connected with the provision of services under this agreement is prohibited, except by written consent of the enrollee, his/her representative, or his/her responsible parent or guardian, or as otherwise provided by law.

10.9.2. The Contractor shall not require parental or guardian consent for, nor inform parents or guardians of, the following services provided to enrollees under age eighteen (18): reproductive health (_State v. Koome_, 1975), sexually-transmitted diseases (RCW 70.24.110), drug and alcohol treatment (RCW 70.96A.095), and mental health (RCW 71.34.200), except as specifically provided in law. The Contractor shall suppress these services on any subscriber reports.

10.9.3. The Contractor and DSHS agree to share information regarding enrollees in a manner which complies with applicable state and federal

law protecting confidentiality of such information (42 CFR 431 Subpart F, RCW 5.60.060(4), RCW 70.02).

10.10. MARKETING: The Contractor, and any subcontractors through which the Contractor provides covered services, shall comply with the following requirements regarding marketing:

10.10.1. Marketing materials means materials distributed to or aimed at Medicaid eligibles, without regard to medium, to influence those individuals to enroll or reenroll in with the Contractor or with the Contractor's subcontractors. All mediums are included but may include brochures, leaflets, newspaper ads, signs, billboards, radio ads, television ads, presentation material for marketing representatives, and websites.

10.10.2. All marketing materials must be reviewed by and have the prior written approval of DSHS.

10.10.3. Marketing materials shall not contain misrepresentations, or false, inaccurate or misleading information.

10.10.4. Marketing materials must be distributed in all services areas the Contractor serves.

10.10.5. Marketing materials must be in compliance with Section 4.7. Marketing materials in English must give directions in the Medicaid eligible population's primary languages for obtaining understandable materials in accord with contract section 4.7.2. DSHS may determine, in its sole judgment, if materials which are primarily visual meet the requirements of contract section 4.7.

10.10.6. The Contractor shall not offer anything of value as an inducement to enrollment.

10.10.7. The Contractor shall not use the sale of other insurance to attempt to influence enrollment.

10.10.8. The Contractor shall not directly or indirectly conduct door-to-door, telephonic or other cold-call marketing of enrollment.

10.11. INFORMATION REQUIREMENTS FOR ENROLLEES AND POTENTIAL ENROLLEES: The Contractor must provide sufficient, accurate oral and written information to potential enrollees to assist them in making an informed decision about enrollment (SSA 1932(d)(2)). The Contractor shall provide to potential enrollees upon request and to each enrollee, within fifteen (15) working days of enrollment, at any time upon request, and at least once a year, the

information needed to understand benefit coverage and obtain care. All enrollee information shall have the prior written approval of DSHS.

The Contractor's written information to enrollees and potential enrollees must include:

10.11.1. How to choose a PCP, including how to request a list of PCPs that includes their identity, location, qualifications and availability.

10.11.2. How obtain a list of specialists that includes their identity, location, qualifications and availability.

10.11.3. How to obtain information regarding any limitations to the availability of or referral to specialists to assist the enrollee in selecting a PCP.

10.11.4. How to obtain information regarding Physician Incentive Plans.

10.11.5. How to change a PCP.

10.11.6. Informed consent guidelines.

10.11.7. Information regarding conversion rights under RCW 48.46.450 or RCW 48.44.370.

10.11.8. How to request a disenrollment.

10.11.9. Information regarding advance directives.

10.11.10. How to recommend changes in the Contractor's policies and procedures.

10.11.11. Health promotion, health education and preventive health services available.

10.11.12. How to obtain assistance from the Contractor in using the complaint and appeal process, including independent review (must assure enrollees that information will be kept confidential except as needed to process the complaint or appeal).

10.11.13. The right to initiate a complaint or file an appeal, including independent review, in accord with the Contractor's DSHS approved policies and procedures regarding complaints and appeals.

10.11.14. The right to request a DSHS Fair Hearing with no requirement to exhaust the Contractor's complaint and appeal process, and how to do so.

10.11.15. The enrollee's rights and responsibilities with respect to receiving covered services.

10.11.16. Information about covered benefits and how to contact DSHS regarding services that may be covered by DSHS, but are not covered benefits under this agreement.

10.12. PHYSICIAN INCENTIVE PLAN INFORMATION: The Contractor must provide information concerning physician incentive plans upon request to enrollees enrolled under the terms of this agreement (42 CFR 434.70(a)(4)).

10.13. FAIR HEARING INFORMATION: The Contractor shall provide information to enrollees about their right to file a Fair Hearing request and how to do so, pursuant to WAC 388-02, and their right to a second opinion, if services or a referral for services have been denied, discontinued or modified.

10.14. PROHIBITION ON ENROLLEE CHARGES FOR COVERED SERVICES: Under no circumstances shall the Contractor, or any providers used to deliver services covered under the terms of this agreement, charge enrollees for covered services (SSA 1932(b)(6), SSA 1128B(d)(1)).

10.15. PROHIBITION ON PROVIDER/ENROLLEE DISCUSSION LIMITATIONS: The Contractor shall not prohibit any health care professional from fully discussing an enrollee's condition and all available treatment options, regardless of whether such treatment options are covered under the terms of this agreement (SSA 1932(b)(3)).

10.16. PROVIDER LICENSE NONDISCRIMINATION: The Contractor shall not discriminate, with respect to participation, reimbursement, or indemnification, against providers practicing within their licensed scope of practice solely on the basis of the type of license or certification they hold. This provision shall not be construed to prohibit the Contractor from otherwise limiting participation to meet its service and cost control needs, and standards for quality of care (SSA 1932(b)(7)).

10.17. EXPERIMENTAL AND INVESTIGATIONAL SERVICES:

10.17.1. If the Contractor excludes or limits benefits for any services for one or more medical conditions or illnesses because such services are deemed to be experimental or investigational, the Contractor must develop and follow policies and procedures for such exclusions and limitations. The policies and procedures shall identify the persons

responsible for such decisions. The policies and procedures and any criteria for making decisions shall be made available to DSHS upon request.

In making the determination, whether a service is experimental and investigational and, therefore, not a covered service, the Contractor shall consider the following:

10.17.1.1. Evidence in peer-reviewed, medical literature, as defined in Section 1.13, and pre-clinical and clinical data reported to the National Institute of Health and/or the National Cancer Institute, concerning the probability of the service maintaining or significantly improving the enrollee's length or quality of life, or ability to function, and whether the benefits of the service or treatment are outweighed by the risks of death or serious complications.

10.17.1.2. Whether evidence indicates the service or treatment is likely to be as beneficial as existing conventional treatment alternatives.

10.17.1.3. Any relevant, specific aspects of the condition.

10.17.1.4. Whether the service or treatment is generally used for the condition in the state of Washington.

10.17.1.5. Whether the service or treatment is under continuing scientific testing and research.

10.17.1.6. Whether the service or treatment shows a demonstrable benefit for the condition.

10.17.1.7. Whether the service or treatment is safe and efficacious.

10.17.1.8. Whether the service or treatment will result in greater benefits for the condition than another generally available service.

10.17.1.9. If approval is required by a regulating agency, such as the Food and Drug Administration, whether such approval has been given before the date of service.

10.17.2. Criteria to determine whether a service is experimental or investigational must be no more stringent for Healthy Options enrollees than that applied to any other enrollees. A service or treatment that is not experimental for one enrollee with a particular medical condition cannot be determined to be experimental for another enrollee with the same medical condition and similar health status.

10.17.3. A service or treatment may not be determined to be experimental and investigational solely because it is under clinical investigation when there is sufficient evidence in peer-reviewed medical literature to draw conclusions, and the evidence indicates the service or treatment will probably be of significant benefit to enrollees.

10.17.4. A determination made by the Contractor shall be subject to appeal through the Contractor's appeal process, including independent review, and through the DSHS fair hearing process.

11. SCHEDULE OF BENEFITS

11.1. COVERED SERVICES:

11.1.1. The Contractor shall cover the services described in this Section when medically necessary. The amount and duration of covered services that are medically necessary depends on the enrollee's condition.

11.1.2. Except as specifically provided herein, the scope of covered services shall be comparable to the DSHS Medicaid fee-for-service program. For specific covered services, this shall not be construed as requiring the Contractor to cover the specific items covered by DSHS under its fee-for-service program, but shall rather be construed to require the Contractor to cover the same scope of services.

11.1.3. Enrollees have the right to self-refer for certain services to providers paid through separate arrangements with the State of Washington. The Contractor is not responsible for the coverage of the services provided through such separate arrangements. The enrollees also may choose to receive such services from the Contractor. The Contractor shall assure that enrollees are informed, whenever appropriate, of all options in such a way as not to prejudice or direct the enrollee's choice of where to receive the services. If the Contractor in any manner deprives enrollees of their free choice to receive services through the Contractor, the Contractor shall pay the local health department, family planning facility, or RSN for such services up to the limits described herein. The services to which an enrollee may self-refer are:

11.1.3.1. Outpatient mental health services to community mental health providers of the Regional Support Network for Prepaid Health Plan.

11.1.3.2. Family planning services and sexually transmitted disease screening and treatment services provided at family planning facilities, such as Planned Parenthood.

11.1.3.3. Immunizations, sexually-transmitted disease screening and follow-up, immunodeficiency virus (HIV) screening, tuberculosis screening and follow-up, and family planning services through the local health department.

11.1.3.4. Medical services provided to enrollees who have a diagnosis of alcohol and/or chemical dependency are covered when those services are otherwise covered services.

11.1.4. INPATIENT SERVICES: Provided by acute care hospitals (licensed under RCW 70.41), or nursing facilities (licensed under RCW 18-51) when nursing facility services are not covered by the Department's Aging and Adult Services Administration and the Contractor determines that nursing facility care is more appropriate than acute hospital care. Inpatient physical rehabilitation services are included.

11.1.5. OUTPATIENT HOSPITAL SERVICES: Provided by acute care hospitals (licensed under RCW 70.41).

11.1.6. EMERGENCY SERVICES: In accord with the requirements of 42 CFR 438.114, all inpatient and outpatient services that are provided by a provider who is qualified to furnish Medicaid services, without regard to whether the provider is a participating or non-participating provider, which are necessary to evaluate and stabilize an emergency medical condition as defined in Section 1.8.

Emergency services shall be provided without requiring prior authorization.

What constitutes an emergency medical condition may not be limited on the basis of lists of diagnoses or symptoms (42 CFR 438.114(d)(i)).

Services provided when the PCP or other plan representative has instructed the enrollee to seek emergency services, regardless of whether the enrollee's condition meets the prudent layperson standard.

If there is a disagreement between a hospital and the Contractor concerning whether the patient is stable enough for discharge or transfer, or whether the medical benefits of an unstabilized transfer outweigh the risks, the judgment of the attending physician(s) actually caring for the enrollee at the treating facility prevails and is binding on the Contractor.

Any post-stabilization services, related to the admitting diagnosis, up to the point of discharge, that the Contractor has either:

11.1.6.1. Authorized

11.1.6.2. Failed to authorize because the Contractor did not respond within thirty (30) minutes to a request for authorization for post-stabilization services (RCW 48.43.093(d))

11.1.6.3. Failed to authorize due to circumstances beyond the emergency department's control

11.1.7. AMBULATORY SURGERY CENTER: Services provided at ambulatory surgery centers.

11.1.8. PROVIDER SERVICES: Services provided in an inpatient or outpatient (e.g., office, clinic, emergency room or home) setting by licensed professionals including, but not limited to, physicians, physician assistants, advanced registered nurse practitioners, midwives, podiatrists, audiologists, registered nurses, and certified dietitians.

Provider Services include, but are not limited to:

11.1.8.1. Medical examinations, including wellness exams for adults and EPSDT for children

11.1.8.2. Immunizations

11.1.8.3. Maternity care

11.1.8.4. Family planning services provided or referred by a participating provider or practitioner

11.1.8.5. Performing and/or reading diagnostic tests

11.1.8.6. Private duty nursing

11.1.8.7. Surgical services

11.1.8.8. Surgery to correct defects from birth, illness, or trauma, or for mastectomy reconstruction

11.1.8.9. Anesthesia

11.1.8.10. Administering pharmaceutical products

11.1.8.11. Fitting prosthetic and orthotic devices

11.1.8.12. Rehabilitation services

11.1.8.13. Enrollee health education

11.1.8.14. Nutritional counseling for specific conditions such as diabetes, high blood pressure, and anemia

11.1.8.15. Nutritional counseling when referred as a result of an EPSDT exam

11.1.9. TISSUE AND ORGAN TRANSPLANTS: Heart, kidney, liver, bone marrow, lung, heart-lung, pancreas, kidney-pancreas, cornea, and peripheral blood stem cell.

11.1.10. LABORATORY, RADIOLOGY, AND OTHER MEDICAL IMAGING SERVICES: Screening and diagnostic services and radiation therapy.

11.1.11. VISION CARE: Eye examinations for visual acuity and refraction once every twenty-four (24) months for adults and once every twelve (12) months for children under age twenty-one (21). These limitations do not apply to additional services needed for medical conditions. The Contractor may restrict non-emergent care to participating providers. Enrollees may self-refer to participating providers for these services.

11.1.12. OUTPATIENT MENTAL HEALTH:

11.1.12.1. Psychiatric and psychological testing, evaluation and diagnosis:

11.1.12.1.1. Once every twelve (12) months for adults twenty-one (21) and over

11.1.12.1.2. Unlimited for children under age twenty-one (21) when identified in an EPSDT visit

11.1.12.2. Unlimited medication management:

11.1.12.2.1. Provided by the PCP or by PCP referral

11.1.12.2.2. Provided in conjunction with mental health treatment covered by the Contractor

11.1.12.3. Twelve hours per calendar year for treatment

11.1.12.4. Transition to the RSN, as needed to assure continuity of care, when the enrollee has exhausted the benefit covered by the Contractor or when enrollee request such transition

11.1.12.5. Referrals To and From the RSN:

11.1.12.5.1. The Contractor shall cover mental health services provided by the RSN, up to the limits described herein, if the Contractor refers an enrollee to the RSN for those services.

11.1.12.5.2. The Contractor may, but is not required to, accept referrals from the RSN for the mental health services described herein.

11.1.12.6. The Contractor may subcontract with RSNs to provide the outpatient mental health services that are the responsibility of the Contractor. Such agreements shall not be written or construed in a manner that provides less than the services otherwise described in this Section as the Contractor's responsibility for outpatient mental health services.

11.1.12.7. The DSHS Mental Health Division (MHD) and Medical Assistance Administration (MAA) shall each appoint a Mental Health Care Coordinator (MHCC). The MHCCs shall be empowered to decide all Contractor and RSN issues regarding outpatient mental health coverage that cannot be otherwise resolved between the Contractor and the RSN. The MHCCs will also undertake training and technical assistance activities that further coordination of care between MAA, MHD, Healthy Options contractors and RSNs. The Contractor shall cooperate with the activities of the MHCCs.

11.1.13. OCCUPATIONAL THERAPY, SPEECH THERAPY, AND PHYSICAL THERAPY: Services for the restoration or maintenance of a function affected by an enrollee's illness, disability, condition or injury, or for the amelioration of the effects of a developmental disability.

11.1.14. PHARMACEUTICAL PRODUCTS: Prescription drug products according to a Department approved formulary, which includes both legend and over-the-counter (OTC) products. The Contractor's formulary shall include all therapeutic classes in DSHS' fee-for-service drug file and a sufficient variety of drugs in each therapeutic class to meet medically necessary health needs. The Contractor shall provide participating pharmacies and participating providers with its formulary and information about how to request non-formulary drugs. The Contractor shall approve or deny all requests for non-formulary drugs by the business day following the day of request.

Covered drug products shall include:

11.1.14.1. Oral, enteral and parenteral nutritional supplements and supplies, including prescribed infant formulas

11.1.14.2. All Food and Drug Administration (FDA) approved contraceptive drugs, devices, and supplies; including but not limited to Depo-Provera, Norplant, and OTC products

11.1.14.3. Antigens and allergens

11.1.14.4. Therapeutic vitamins and iron prescribed for prenatal and postnatal care.

11.1.15. HOME HEALTH SERVICES: Home health services through state-licensed agencies.

11.1.16. DURABLE MEDICAL EQUIPMENT (DME) AND SUPPLIES: Including, but not limited to: DME; surgical appliances; orthopedic appliances and braces; prosthetic and orthotic devices; breast pumps; incontinence supplies for enrollees over three (3) years or age; and medical supplies. Incontinence supplies shall not include non-disposable diapers unless the enrollee agrees.

11.1.17. OXYGEN AND RESPIRATORY SERVICES: Oxygen, and respiratory therapy equipment and supplies.

11.1.18. HOSPICE SERVICES: When the enrollee elects hospice care.

11.1.19. BLOOD, BLOOD COMPONENTS AND HUMAN BLOOD PRODUCTS: Administration of whole blood and blood components as well as human blood products. In areas where there is a charge for blood and/or blood products the Contractor shall cover the cost of the blood or blood products.

11.1.20. TREATMENT FOR RENAL FAILURE: Hemodialysis, or other appropriate procedures to treat renal failure, including equipment needed in the course of treatment.

11.1.21. AMBULANCE TRANSPORTATION: The Contractor shall cover ground and air ambulance transportation for emergency medical conditions, as defined in Section 1.8 of this agreement, including, but not limited to, Basic and Advanced Life Support Services, and other required transportation costs, such as tolls and fares. In addition, the Contractor shall cover ambulance services under two circumstances for non-emergencies:

11.1.21.1. When it is necessary to transport an enrollee between facilities to receive a covered services; and,

11.1.21.2. When it is necessary to transport an enrollee, who must be carried on a stretcher, or who may require medical attention en route (RCW 18.73.180) to receive a covered service.

11.1.22. CHIROPRACTIC SERVICES: For children when they are referred during an EPSDT exam.

11.1.23. NEURODEVELOPMENTAL SERVICES: When provided by a facility that is not a DSHS recognized neurodevelopmental center.

11.1.24. SMOKING CESSATION SERVICES: For pregnant women through sixty (60) days post pregnancy.

11.2. EXCLUSIONS:

The following services and supplies are excluded from coverage under this agreement. This shall not be construed to prevent the Contractor from covering any of these services when the Contractor determines it is medically necessary. Unless otherwise required by this agreement, ancillary services resulting from excluded services are also excluded.

11.2.1. SERVICES COVERED BY DSHS FEE-FOR-SERVICE OR THROUGH SELECTIVE CONTRACTS:

11.2.1.1. School Medical Services for Special Students as described in the DSHS billing instructions for School Medical Services.

11.2.1.2. Eyeglass Frames, Lenses, and Fabrication Services covered under DSHS' selective contract for these services, and associated fitting and dispensing services.

11.2.1.3. Voluntary Termination of Pregnancy, including complications.

11.2.1.4. Transportation Services other than Ambulance: Taxi, cabulance, voluntary transportation, and public transportation.

11.2.1.5. Dental Care, Prostheses and Oral Surgery, including physical exams required prior to hospital admissions for oral surgery.

11.2.1.6. Hearing Aid Devices, including fitting, follow-up care and repair.

11.2.1.7. First Steps Maternity Case Management and Maternity Support Services.

11.2.1.8. Sterilizations for enrollees under age 21, or those that do not meet other federal requirements.

11.2.1.9. Health care services provided by a neurodevelopmental center recognized by DSHS.

11.2.1.10. Certain services provided by a health department or family planning clinic when a client self-refers for care.

11.2.1.11. Inpatient psychiatric professional services.

11.2.1.12. Pharmaceutical products prescribed by any provider related to services provided under a separate agreement with DSHS or related to services not covered by the Contractor.

11.2.1.13. Laboratory services required for medication management of drugs prescribed by community mental health providers whose services are purchased by the Mental Health Division.

11.2.1.14. Protease Inhibitors

11.2.1.15. Services ordered as a result of an EPSDT exam that are not otherwise covered services.

11.2.1.16. Gastroplasty

11.2.1.17. Prenatal Diagnosis Genetic Counseling provided to enrollees to allow enrollees and their PCPs to make informed decisions regarding current genetic practices and testing. Genetic services beyond Prenatal Diagnosis Genetic Counseling are covered as maternity care when medically necessary, see Section 11.1.8.3.

11.2.1.18. Gender dysphoria surgery and related procedures, treatment, prosthetics, or supplies when approved by DSHS in accord with WAC 388-531.

11.2.2. SERVICES COVERED BY OTHER DIVISIONS IN THE DEPARTMENT OF SOCIAL AND HEALTH SERVICES:

11.2.2.1. Substance abuse treatment services covered through the Division of Alcohol and Substance Abuse (DASA), including inpatient detoxification services for alcohol (3-day) and drugs (5-day) with no complicating medical conditions.

11.2.2.2. Nursing facility and community based services (e.g. COPES and Personal Care Services) covered through the Aging and Adult Services Administration.

11.2.2.3. Mental health services separately purchased for all Medicaid clients by the Mental Health Division, including 24-hour crisis intervention, outpatient mental health treatment services, and inpatient psychiatric services. This shall not be construed to prevent the Contractor from purchasing covered outpatient mental health services from community mental health providers.

11.2.2.4. Health care services covered through the Division of Developmental Disabilities for institutionalized clients.

11.2.3. SERVICE COVERED BY OTHER STATE AGENCIES:

Infant formula for oral feeding provided by the Women, Infants and Children (WIC) program in the Department of Health. Medically necessary nutritional supplements for infants are covered under the pharmacy benefit.

11.2.4. SERVICES NOT COVERED BY EITHER DSHS OR THE CONTRACTOR:

11.2.4.1. Medical examinations for Social Security Disability.

11.2.4.2. Services for which plastic surgery or other services are indicated primarily for cosmetic reasons.

11.2.4.3. Physical examinations required for obtaining continuing employment, insurance or governmental licensing.

11.2.4.4. Experimental and Investigational Treatment or Services, determined in accord with Section 10.18, Experimental and Investigational Services, and services associated with experimental or investigational treatment or services.

11.2.4.5. Reversal of voluntary surgically induced sterilization.

11.2.4.6. Personal Comfort Items, including but not limited to guest trays, television and telephone charges.

11.2.4.7. Biofeedback Therapy.

11.2.4.8. Diagnosis and treatment of infertility, impotence, and sexual dysfunction.

11.2.4.9. Orthoptic (eye training) care for eye conditions.

11.2.4.10. Tissue or organ transplants that are not specifically listed as covered.

11.2.4.11. Immunizations required for international travel purposes only.

11.2.4.12. Court-ordered services.

11.2.4.13. Any service provided to an incarcerated enrollee, beginning when a law enforcement officer takes the enrollee into legal custody.

11.2.4.14. Any service, product, or supply paid for by DSHS under its fee-for-service program only on an exception to policy basis. The Contractor may also make exceptions and pay for services it is not required to cover under this agreement.

11.2.4.15. Any other service, product, or supply not covered by DSHS under its fee-for-service program.

EXHIBIT A-1
QUALITY IMPROVEMENT STANDARDS
2003 STANDARDS
NCQA

The Contractor shall comply with the Quality Improvement Program 2003 Standards. The standards are adopted primarily from NCQA's Standards for the Accreditation of Managed Care Organizations. DSHS is implementing as the Quality Improvement Program 2003 Standards, standards which are substantially the same as the Quality Improvement Program Standards in the 2002 HO/SCHIP Contract. DSHS reserves the right to revise the Quality Improvement Program 2003 Standards to ensure that no standard is in conflict with the Washington State Patient Bill of Rights (PBOR), Health Insurance Portability and Accountability Act (HIPAA), or any other applicable state or federal statute or regulation. In the event of conflict between the Quality Improvement Program 2003 Standards and the standards in PBOR, HIPAA, or state or federal statute or regulation, the standard which, in the sole judgment of DSHS, is most favorable to enrollees shall have precedence.

DSHS agrees that any Contractor that meets or exceeds a 90% TEAMonitor score on a specific quality standard (Quality Management and Improvement, Utilization Management, Credentialing and Recredentialing, Members' Rights and Responsibilities, Preventive Health Services and Medical Records) over two consecutive audit years to be in compliance with that specific standard for the next audit year. If DSHS has evidence that subsequent performance has been deficient, the CONTRACTOR shall be subject to audit on all standards. In determining whether a Contractor's performance has been deficient with respect to the Quality Improvement Standards, DSHS will consider NCQA Reports, enrollee complaints, appeals and denials, and any other substantial data or information.

The above process shall not apply to areas specifically required for annual review by The Federal Medicaid Act (Social Security Act, 42. US. C. Sec. 1396 et seq.), applicable federal regulations, The Healthy Options Waiver 1115b, Guidelines for Addressing Fraud and Abuse in Medicaid Managed Care, The Balanced Budget Act of 1997 and any published, applicable BBA regulations; applicable RCWs and applicable WACs.

The following NCQA definitions apply to terms used in this document:

COMPLAINT: A term commonly used to describe an oral or written expression of dissatisfaction by a member.

APPEAL: A formal request by a practitioner or covered person for reconsideration of a decision such as a utilization review recommendation, a benefit payment, an administrative action, quality of care or service issue, with the goal of finding a mutually acceptable solution.

PRACTITIONER: Any individual who is qualified to practice a profession. Practitioners are usually required to be licensed as defined by law.

PROVIDER: An institution or organization that provides services for your organization's members. Examples of providers include hospitals and home health agencies.

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QUALITY MANAGEMENT AND IMPROVEMENT

QI 1 PROGRAM STRUCTURE

The managed care organization's (MCO) quality improvement (QI) structures and processes are clearly defined, and responsibility is assigned to appropriate individuals.

QI 1.1 A written description of the QI program outlines the program structure and content.

QI 1.1.2 The description of the program includes a section that addresses improving patient safety.

QI 1.2 The QI program is accountable to the governing body.

QI 1.3 The program description is evaluated annually and updated as necessary.

QI 1.4 A designated physician has substantial involvement in the implementation of the QI program.

QI 1.5 A committee oversees and is involved in QI activities.

QI 1.6 The program description specifies the role, structure, and function, including frequency of meetings of the QI committee and other relevant committees.

QI 1.7 The annual QI work plan, or schedule of activities, includes the following:

QI 1.7.1 objectives, scope, and planned projects or activities that address the quality and safety of clinical care and the quality of service for the year;

QI 1.7.2 planned monitoring of previously identified issues, including tracking of issues over time and

QI 1.7.3 planned evaluation of the QI program as described in QI 12.1.

QI 1.8 The QI program resources (e.g. personnel, analytic capabilities, data resources) are adequate to meet its needs.

QI 2 PROGRAM OPERATIONS

The managed care organization's quality improvement program is fully operational.

QI 2.1 The QI committee recommends policy decisions, reviews and evaluates the results of QI activities, institutes needed actions, and ensures follow-up, as appropriate.

QI 2.2 There are contemporaneous minutes (i.e. created at the time the activity is conducted), dated and signed, that reflect all QI committee decisions and actions.

QI 2.3 The MCO's practitioners participate actively in the QI program.

QI 2.4 Upon request, the MCO makes available to its members and practitioners information about its QI program, including a description of the QI program and a report on the MCO's progress in meeting its goals.

QI 3 HEALTH SERVICES CONTRACTING

Contracts with individual practitioners and organizational providers, including those making UM decisions, specify that contractors cooperate with the managed care organization's QI program.

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QI 3.1 Contracts with practitioners specifically require that:

QI 3.1.1 the practitioners cooperate with QI activities;

QI 3.1.2 the MCO has access to the practitioners' medical records to the extent permitted by state and federal law and

QI 3.1.3 the MCO allows open practitioner-patient communication regarding appropriate treatment alternatives and without penalizing practitioners for discussing medically necessary or appropriate care for the patient.

QI 3.2 Contracts with providers specifically require that:

QI 3.2.1 the providers cooperate with QI activities and

QI 3.2.2 the MCO has access to the provider's medical records to the extent permitted by state and federal law.

QI 4 AVAILABILITY OF PRACTITIONERS

The MCO ensures that its network is sufficient in numbers and types of practitioners.

QI 4.1 In creating and maintaining its delivery system of practitioners, the MCO takes into consideration assessed special and cultural needs and preferences.

QI 4.2 The MCO implements mechanisms designed to ensure the availability of PCPs.

QI 4.2.1 The MCO defines the practitioners who serve as PCPs within its delivery system.

QI 4.2.2 The MCO establishes standards for number and geographic distribution of PCPs.

QI 4.2.3 The MCO collects and analyzes data to measure its performance against the standards established in QI 4.2.2.

QI 4.2.4 The MCO identifies opportunities for improvement and decides which opportunities to pursue.

QI 4.2.5 The MCO implements interventions to improve its performance.

QI 4.2.6 The MCO measures the effectiveness of the interventions.

QI 4.3 The MCO implements mechanisms designed to ensure the availability of specialty care practitioners.

QI 4.3.1 The MCO establishes standards for number and geographic distribution of specialty practitioners.

QI 4.3.2 The MCO collects and analyzes data to measure its performance against the standards established in QI 4.3.1.

QI 4.3.3 The MCO identifies opportunities for improvement and decides which opportunities to pursue.

QI 4.3.4 The MCO implements interventions to improve its performance.

QI 4.3.5 The MCO measures the effectiveness of the interventions.

QI 5 ACCESSIBILITY OF SERVICES

The MCO establishes mechanisms to assure the accessibility of primary care services, behavioral health services and member services.

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QI 5.1 The MCO establishes standards for access to medical care:

QI 5.1.1 preventive care appointments;

QI 5.1.2 routine primary care appointments;

QI 5.1.3 urgent care appointments;

QI 5.1.4 emergency care; and

QI 5.1.5 after-hours care.

QI 5.2 The MCO establishes standards for key elements of telephone customer service.

QI 5.4 The MCO collects and analyzes data to measure its performance against the standards.

QI 5.5 The MCO identifies opportunities for improvement and decides which opportunities to pursue.

QI 5.6 The MCO implements interventions to improve its performance.

QI 5.7 The MCO measures the effectiveness of the interventions.

QI 6 MEMBER SATISFACTION

The MCO implements mechanisms to assure member satisfaction.

QI 6.1 The MCO assesses member satisfaction by:

QI 6.1.1 evaluating member complaints and appeals and

QI 6.1.2 evaluating requests to change practitioners and/or sites.

QI 6.2 The MCO uses appropriate methods to collect data for the activities listed in QI 6.1:

QI 6.2.1 The appropriate population identified.

QI 6.2.2 If sampling used, appropriate samples are drawn from the affected population.

QI 6.2.3 Valid and reliable data are collected.

QI 6.3 The MCO analyzes data from at least the activities listed in QI 6.1 and the CAHPS(R) 2.0H survey.

QI 6.4 The MCO identifies opportunities for improvement and decides which opportunities to pursue.

QI 6.5 The MCO implements interventions to improve its performance.

QI 6.6 The MCO measures the effectiveness of the interventions.

QI 6.7 The MCO informs practitioners and providers of results of member satisfaction activities.

QI 7 HEALTH MANAGEMENT SYSTEMS

The MCO actively works to improve the health status of its members with chronic conditions.

QI 7.1 The MCO identifies members with chronic conditions and offers appropriate services and programs to assist in managing their conditions.

QI 7.2 The MCO informs and educates practitioners about using the health management programs for the members assigned to them.

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QI 8 CLINICAL PRACTICE GUIDELINES

The MCO is accountable for adopting and disseminating practice guidelines for the provision of acute, chronic and behavioral health services that are relevant to its enrolled membership.

QI 8.1 The clinical practice guidelines are based on reasonable medical evidence.

QI 8.2 The MCO involves its practitioners in the adoption of clinical practice guidelines.

QI 8.3 The MCO has developed a mechanism for reviewing the guidelines at least every two years and updating them as appropriate.

QI 8.4 The MCO distributes the guidelines to its practitioners.

QI 8.5 Annually, the MCO measures performance against at least three guidelines, one of which relates to behavioral health.

QI 8.6 Decision making in utilization management, member education, interpretation of covered benefits and other areas to which the clinical guidelines are applicable is consistent with the guidelines.

QI 9 CONTINUITY AND COORDINATION OF CARE

The MCO monitors the continuity and coordination of care that members receive.

QI 9.1 The MCO monitors the continuity and coordination of care that members receive across practices and provider sites, including at minimum PCP sites with 50 or more members.

QI 9.2 The MCO monitors the continuity and coordination of general medical care with behavioral health care. To this end, the MCO collaborates with its behavioral health specialists to:

QI 9.2.1 Exchange information in an effective, timely and confidential manner, including patient-approved communications between medical practitioners and behavioral health practitioners and providers.

QI 9.3 The MCO collects and analyzes data to evaluate continuity and coordination of care.

QI 9.3.1 The MCO analyzes data to identify opportunities for improvement.

QI 9.4 The MCO implements interventions to improve continuity and coordination of care.

QI 9.4.1 The MCO implements interventions when it identifies an opportunity for improvement.

QI 9.5 To ensure the continuity and coordination of care, the MCO notifies members affected by the termination of a practitioner or practice site and assists them in selecting a new practitioner or site.

QI 10 CLINICAL MEASUREMENT ACTIVITIES

The MCO uses data collection, measurement and analysis to track clinical issues that are relevant to its population.

QI 10.1 At a minimum, the MCO adopts or establishes quantitative measures to assess performance and to identify and prioritize areas for improvement for three clinical issues, including at least one behavioral health issue.

QI 10.1.1 The measures used to assess performance are objective and quantifiable.

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QI 10.1.2 The measures are based on current scientific knowledge and clinical experience.

QI 10.1.3 Each measure has an established goal and/or benchmark.

QI 10.2 The MCO uses appropriate methods to collect data for each assessment measure.

QI 10.2.1 The affected population is identified.

QI 10.2.2 If sampling used, appropriate samples are drawn from the affected population.

QI 10.2.3 Valid and reliable data collected.

QI 10.3 The MCO analyzes data collected for each assessment measure.

QI 10.3.1 There is a quantitative analysis of the assessment data.

QI 10.3.2 Appropriate personnel, including practitioners, evaluate the analyzed data to identify barriers to improvement that are related to clinical practice and/or administrative aspects of the delivery system.

QI 11 INTERVENTION AND FOLLOW UP FOR CLINICAL ISSUES

The MCO takes action to improve quality by addressing the opportunities for improving performance identified in QI 10. The MCO also assesses the effectiveness of these interventions through systematic follow-up.

QI 11.1 The MCO follows up the opportunities for improvement identified through assessment and evaluation activities.

QI 11.1.1 The MCO identifies opportunities for improvement and decides which opportunities to pursue.

QI 11.1.2 The MCO implements interventions to improve practitioner and system performance, as appropriate.

QI 11.1.3 The MCO measures whether the interventions have been effective.

QI 12 EFFECTIVENESS OF THE QI PROGRAM

The MCO evaluates the overall effectiveness of its QI program in addressing the quality and safety of clinical care and demonstrates improvements in the quality of clinical care and quality of service to its members.

QI 12.1 There is an annual written evaluation of the QI program. This evaluation includes:

QI 12.1.1 a description of completed and ongoing QI activities that address the quality and safety of clinical care and the quality of service;

QI 12.1.2 trending of measures to assess performance in the quality and safety of clinical care and the quality of service;

QI 12.1.2 an analysis of whether there have been demonstrated improvements in the quality of clinical care and the quality of service to members and

QI 12.1.3 an evaluation of the overall effectiveness of the QI program, including progress toward influencing safe clinical practices throughout the network.

QI 12.2 There is evidence that QI activities have contributed to meaningful improvement in the quality of clinical care and quality of service provided to members.

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QI 13 DELEGATION OF QI ACTIVITY

If the MCO delegates any QI activities, there is evidence of oversight of the delegated activity.

QI 13.1 A mutually agreed upon document describes:

QI 13.1.1 the responsibilities of the MCO and the delegated entity;

QI 13.1.2 the delegated activities;

QI 13.1.3 the frequency of reporting to the MCO;

QI 13.1.4 the process by which the MCO evaluates the delegated entity's performance and

QI 13.1.5 the remedies, including revocation of the delegation, available to the MCO if the delegated entity does not fulfill its obligations.

QI 13.2 There is evidence that the MCO:

QI 13.2.1 evaluates the delegated entity's capacity to perform delegated activities prior to delegation;

QI 13.2.2 approves the delegated entity's QI work plan and QI program description annually;

QI 13.2.3 evaluates regular reports as specified in QI 13.1.3 and

QI 13.2.4 evaluates annually whether the delegated entity's activities are being conducted in accordance with the MCO's expectations and NCQA standards.

UTILIZATION MANAGEMENT

UM1 UTILIZATION MANAGEMENT STRUCTURE

The MCO utilization management (UM) structures and processes are clearly defined and responsibility is assigned to appropriate individuals.

UM 1.1 A written description of the UM program outlines the program structure and accountability.

UM 1.2 A designated senior physician has substantial involvement in the UM program implementation.

UM 1.3 The description includes the scope of the program and the processes and information sources used to make determinations of benefit coverage and medical necessity.

UM 1.4 The UM program is evaluated and approved annually by senior management or the QI committee. It is updated as necessary.

UM 2 CLINICAL CRITERIA FOR UM DECISIONS

To make utilization decisions, the MCO uses written criteria based on sound clinical evidence and specifies procedures for applying those criteria in an appropriate manner.

UM 2.1 The criteria for determining medical necessity are clearly documented and include procedures for applying criteria based on the needs of individual patients and characteristics of the local delivery system.

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UM 2.2 The MCO involves appropriate, actively practicing practitioners in its development or adoption of criteria and in the development and review of procedures for applying the criteria.

UM 2.3 The MCO reviews the criteria at specified intervals and updates them as necessary.

UM 2.4 The MCO states in writing how practitioners can obtain the UM criteria and makes the criteria available to its practitioners upon request.

UM 2.5 At least annually, the MCO evaluates the consistency with which the health care professionals involved in utilization review apply the criteria in decision making.

UM 3 APPROPRIATE PROFESSIONALS

Qualified licensed health professionals assess the clinical information used to support UM decisions.

UM 3.1 Appropriately licensed health professionals supervise all the review decisions.

UM 3.2 An appropriate practitioner reviews any denial of care.

UM 3.2.1 A licensed physician reviews any denial based on medical necessity.

UM 3.3 The MCO has written procedures for using board-certified physicians from appropriate specialty areas to assist in making determinations of medical necessity.

UM 4 TIMELINESS OF UM DECISIONS/1/

The MCO makes utilization decisions in a timely manner to accommodate the clinical urgency of the situation.

UM 4.1 The MCO follows the NCQA's standards for the timeliness of UM decision making.

UM 4.1.1 For pre-certification of non-urgent care, the MCO makes decisions within two working days of obtaining all the necessary information.

UM 4.1.2 For pre-certification of non-urgent care, the MCO notifies practitioners of the decisions within one working day of making the decision.

UM 4.1.3 For pre-certifications of non-urgent care that result in denial, the MCO gives members and practitioners written or electronic confirmation of the decisions within two working days of making the decision.

UM 4.1.4 For pre-certifications of urgent care, the MCO makes decisions and notifies practitioners of the decisions within one calendar day. If the decision is a denial, the MCO must also notify members within one calendar day.

UM 4.1.5 For pre-certification of urgent care that results in denial, the MCO notifies both members and practitioners how to initiate an expedited appeal at the time they are notified of the denial.

UM 4.1.6 For pre-certification of urgent care that results in denial, the MCO gives members and practitioners written or

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/1/ See Exhibit A-2 for language to ensure compliance with Patient Bill of Rights (PBOR) Legislation.

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electronic confirmation of the decision within two working days of making the decision.

UM 4.1.7 For concurrent review of services, the MCO makes decisions for:

UM 4.1.7.2 See Exhibit A-2, PBOR 4.1.7.2

UM 4.1.8 For concurrent review, the MCO notifies practitioners of decisions within one working day of making the decision.

UM 4.1.9 For concurrent review decisions that result in a denial, the MCO gives members and practitioners written or electronic confirmation within one working day of the original notification.

UM 4.1.10 For concurrent review decisions that result in a denial, the MCO notifies both members and practitioners how to initiate an expedited appeal at the time they are notified of the denial.

UM 4.1.11 For retrospective review, the MCO makes the decision within 30 working days of obtaining all the necessary information.

UM 4.1.12 See Exhibit A-2, PBOR 4.1.12

UM 5 MEDICAL INFORMATION

When making a determination of coverage based on medical necessity, the MCO obtains relevant clinical information and consults with the treating physician.

UM 5.1 A written description identifies the information that is collected to support UM decision making.

UM 5.2 There is documentation that relevant clinical information is gathered consistently to support UM decision making

UM 6 DENIAL NOTICES

The MCO clearly documents and communicates the reasons for each denial.

UM 6.1 The MCO makes available to practitioners a physician reviewer to discuss by telephone determinations based on medical necessity.

UM 6.2 The MCO sends written notification to members and practitioners, as appropriate, of the reason for each denial, including the specific utilization review criteria or benefit provisions used in the determination.

UM 6.3 The MCO includes information about the appeal process in all denial notifications.

UM 7 POLICIES FOR APPEALS[2]

The MCO has written policies and procedures for the thorough, appropriate, and timely resolution of member appeals.

UM 7.1 Procedures for registering and responding to oral and written first-level appeals include the following elements:

UM 7.1.1 notification to the member of the appeal process within five working days of receiving a request for a first-

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/2/ See Exhibit A-2 for language to ensure compliance with PBOR regulations.

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level appeal;

UM 7.1.2 documentation of the substance of the appeal and the actions taken;

UM 7.1.3 full investigation of the substance of appeal, including any aspects of clinical care involved;

UM 7.1.4 resolution of appeal, including:

UM 7.1.4.1 The MCO appoints a person of people to review the first-level appeal who were not involved in initial determination.

UM 7.1.4.2 See Exhibit A-2, PBOR 7.1.4.2

UM 7.1.5 See Exhibit A-2, PBOR 7.1.5

UM 7.1.6 The MCO establishes procedures for registering and responding to expedited first-level appeals.

UM 7.1.6.1 An expedited appeal may be initiated by the member or by the practitioner acting on behalf of the member.

UM 7.1.6.2 See Exhibit A-2, PBOR 7.1.6.2

UM 7.3 A procedure for allowing practitioner or member representative to act on behalf of the member at any level of appeal.

PBOR 1 See Exhibit A-2, PBOR 1

UM 7.4 See Exhibit A-2, PBOR 7.4

UM 7.5 A procedure for providing independent, external review of final determinations including:

UM 7.5.1 See Exhibit A-2, PBOR 7.5.1

UM 7.5.1.1 the member is appealing an adverse determination that is based on medical necessity, as defined NCQA; by

UM 7.5.1.2 See Exhibit A-2, PBOR 7.5.1.2

UM 7.5.1.3 the member has not withdrawn the appeal request, agreed to another dispute resolution proceeding or submitted to an external dispute resolution proceeding required by law.

UM 7.5.2 Notification to members about the independent appeals program as follows:

UM 7.5.2.1 general communications to members announce the availability of the right to independent review.

UM 7.5.2.2 Letters informing members and practitioners of the upholding of a denial by this standard include notice of independent appeal rights and processes, contact information for the IRO and a statement that the member does not bear any costs of the IRO.

UM 7.5.2.3 Letters inform members of the time and procedure for claim payment or approval of service in the event the IRO overturns the managed care organization's decision

UM 7.5.3 CONDUCT OF THE APPEAL PROGRAM AS FOLLOWS:

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UM 7.5.3.2 With the exception of exercising its rights as party to the appeal, the MCO must not attempt to interfere with the IRO's proceeding or appeal decision

UM 7.5.3.3 The member is not required to bear costs of the IRO, including any filing fees.

UM 7.5.3.4 The member or his or her legal guardian may designate in writing a representative to act on his or her behalf.

UM 7.5.3.5 The MCO implements the IRO decision within the time frame specified by the IRO.

UM 7.5.3.6 The MCO obtains from the IRO, or maintains, data on each appeal case, including description so fthe denied item(s), reasons for denial, IRO decisions and reasons for decisions. The MCO uses this information in evaluating its medical necessity decision-making process.

UM 8 APPROPRIATE HANDLING OF APPEALS

UM 8.1 See Exhibit A-2, PBOR 8.1

UM 8.2 independent, external appeals.

CS 1 POLICIES FOR COMPLAINTS see Exhibit A-2 CS 1 through 2.1

UM 9 EVALUATION OF NEW TECHNOLOGY

The MCO evaluates the inclusion of new technologies and the new application of existing technologies in the benefit package. This includes medical and behavioral procedures, pharmaceuticals and devices.

UM 9.1 The MCO has a written description of the process used to determine whether new technologies and new uses of existing technologies are included in the benefit package.

UM 9.2 The MCO implements this process to assess new technologies and new applications of existing technologies.

UM 11 EMERGENCY SERVICES

The MCO provides, arranges for or otherwise facilitates all needed emergency services, including appropriate coverage of costs.

UM 11.1 The MCO covers emergency services necessary to screen and stabilize members without precertification in cases where a prudent layperson, acting reasonably, would have believed an emergency medical condition existed.

UM 11.2 The MCO covers emergency services if an authorized representative acting for the MCO has authorized the provision of emergency services.

UM 12 PROCEDURES FOR PHARMACEUTICAL MANAGEMENT

The MCO ensures that its procedures for pharmaceutical management, if any, promotes clinically appropriate use of pharmaceuticals.

UM 12.1 The MCO's pharmaceutical management procedures are based upon sound clinical evidence, and the organization specifies how to apply the procedures in an appropriate manner based on the needs of individual patients.

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UM 12.2 Where the MCO restricts pharmacy benefits to a closed formulary, it has a process to consider medical necessity exceptions for members to obtain coverage of a pharmaceutical not on the formulary.

UM 13 ENSURING APPROPRIATE UTILIZATION

The MCO facilitates the delivery of appropriate care and monitors the impact of its UM program to detect and correct under- and over utilization of services.

UM 13.1 The MCO monitors relevant utilization data for each product line and behavioral health services by product line to detect potential under- and over-utilization.

UM 13.2 The MCO routinely analyzes all data collected to detect under- and over-utilization.

UM 13.3 The MCO implements appropriate interventions whenever it identifies under- and overutilization.

UM 13.4 The MCO measures whether the interventions have been effective and implement strategies to achieve appropriate utilization.

UM 13.5 The MCO distributes to all its practitioners, providers, members and employees a statement describing its policy on financial incentives and requires practitioners, providers and staff who make utilization-related decisions and those who supervise them to sign a document acknowledging that they have received the statement. This statement affirms that:

UM 13.5.1 UM decision-making is based only on appropriateness of care and service and existence of coverage.

UM 13.5.2 The MCO does not specifically reward practitioners or other individuals conducting utilization review for issuing denials of coverage or service care.

UM 13.5.3 Financial incentives for UM decision makers do not encourage decisions that result in underutilization.

UM 15 DELEGATION OF UM

If the MCO delegates any UM activities, there is evidence of oversight of the delegated activity.

UM 15.1 A mutually agreed upon document describes:

UM 15.1.1 the responsibilities of the MCO and the delegated entity;

UM 15.1.2 the delegated activities;

UM 15.1.3 the frequency of reporting to the MCO;

UM 15.1.4 the process by which the MCO evaluates delegated entity's performance and

UM 15.1.5 the remedies, including revocation of the delegation, available to the MCO if the delegated entity does not fulfill its obligations.

UM 15.2 There is evidence that the MCO:

UM 15.2.1 evaluates the delegated entity's capacity to perform the delegated activities prior to delegation;

UM 15.2.2 approves the delegated entity's UM program annually;

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UM 15.2.3 evaluates regular reports as specified in UM 15.1.3 and

UM 15.2.4 evaluates annually whether the delegated entity's activities are being conducted in accordance with the MCO's expectations & NCQA standards.

CREDENTIALING AND RECREDENTIALING

CR 1 CREDENTIALING POLICIES

The MCO documents the mechanism for the credentialing and recredentialing of licensed independent practitioners with whom it contracts or employs and who fall within its scope of authority and action. At a minimum, the policies and procedures define:

CR 1.1 the scope of practitioners covered;

CR 1.2 the criteria and the primary source verification of information used to meet these criteria;

CR 1.3 the process used to make decisions;

CR 1.4 the process to delegate credentialing or recredentialing;

CR 1.5 the right of practitioners to review the information submitted in support of their credentialing applications;

CR 1.6 the process for notification to a practitioner of any information obtained during the MCO's credentialing process that varies substantially from the information provided to the MCO by the practitioner;

CR 1.7 the practitioner's right to correct erroneous information;

CR 1.8 the medical director's or other designated physician's direct responsibility and participation in the credentialing program and

CR 1.9 the process used to ensure the confidentiality of all information obtained in the credentialing process, except as otherwise provided by law.

CR 2 CREDENTIALING COMMITTEE

The MCO designates a credentialing committee that makes recommendations regarding credentialing decisions using a peer review process.

CR 3 INITIAL PRIMARY SOURCE VERIFICATION

At the time of credentialing, the MCO verifies at least the following information from primary sources (unless otherwise indicated):

CR 3.1 a current valid license to practice;

CR 3.2 a valid DEA or CDS certificate as applicable;

CR 3.3 education and training of practitioners;

CR 3.4 board certification if the practitioner states that he/she is board certified on the application;

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CR 3.5 work history;

CR 3.6 history of professional liability claims that resulted in settlements or judgments paid by or on behalf of the practitioner.

CR 4 APPLICATION AND ATTESTATION

The applicant completes an application for membership. The application includes a current and signed attestation by the applicant regarding:

CR 4.1 reasons for any inability to perform the essential functions of the position, with or without accommodation;

CR 4.2 lack of present illegal drug use;

CR 4.3 history of loss of license and felony convictions;

CR 4.4 history of loss or limitation of privileges or disciplinary activity;

CR 4.5 current malpractice insurance coverage and

CR 4.6 the correctness and completeness of the application.

CR 5 INITIAL SANCTION INFORMATION

There is documentation that before making a credentialing decision, the MCO has received the following information and includes this information in the credentialing files.

CR 5.1 The MCO has received information from the National Practitioner Data Bank (NPDB) and includes it in the credentialing files.

CR 5.2 The MCO has received information about sanctions or limitations on licensure as applicable and includes it in the credentialing files.

CR 5.3 The MCO has reviewed for previous sanction activity by Medicare and Medicaid and includes it in the credentialing files.

CR 6 INITAL CREDENTIALING SITE VISITS

The MCO has a process for ensuring that the offices of all PCPs, obstetricians/gynecologists and high volume behavioral health care practitioners meet the MCO's office site standards

CR 7 RECREDENTIALING PRIMARY SOURCE VERIFICATION

The MCO formally recredentials its practitioners at least every three years. During the recredentialing process it verifies at least the following information from primary sources (unless otherwise indicated):

CR 7.1 a valid state license to practice;

CR 7.2 a valid DEA or CDS certificate, as applicable;

CR 7.3 board certification, if the practitioner states that he/she is board certified;

CR 7.4 history of professional liability claims that resulted in settlements or judgments paid by or on behalf of the

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practitioner;

CR 7.5 a current, signed attestation by the applicant regarding:

CR 7.5.1 reasons for any inability to perform the essential functions of the position, with or without accommodation;

CR 7.5.2 lack of present illegal drug use;

CR 7.5.3 history of loss or limitation of privileges or disciplinary activity;

CR 7.5.4 current malpractice insurance coverage and

CR 7.5.5 the correctness and completeness of the application.

CR 8 RECREDENTIALING SANCTION INFORMATION

There is documentation that, before making a recredentialing decision, the MCO has received the following information on the practitioner and includes this information in the recredentialing files.

CR 8.1 The MCO has received information from the National Practitioner Data Bank and includes it in the recredentialing files.

CR 8.2 The MCO has received information about sanctions or limitations on licensure, as applicable, and includes it in the recredentialing files:

CR 8.3 The MCO has reviewed for previous sanction activity by Medicare and Medicaid and records this in the recredentialing files.

CR 9 PERFORMANCE MONITORING

The MCO incorporates information from quality improvement activities in its recredentialing decision-making process for PCPs and high-volume behavioral health care practitioners.

CR 9.1 member complaints

CR 9.2 information from QI activities.

CR 10 ONGOING MONITORING OF SANCTIONS AND COMPLAINTS

The MCO has implemented policies and procedures for the ongoing monitoring of practitioner sanctions and complaints between recredentialing cycles. The MCO has taken appropriate action against practitioners when it identifies occurrences of poor quality.

CR 10.1 The MCO has a written policy and procedure that addresses the ongoing monitoring and use of the following types of information:

CR 10.1.1 Medicare and Medicaid sanctions;

CR 10.1.2 sanctions and limitations on licensure and

CR 10.1.3 complaints

CR 10.2 The MCO implements the policy and procedure by regularly obtaining and reviewing documentation on sanctions

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and complaints.

CR 10.3 The MCO implements appropriate interventions when it identifies occurrences of poor quality.

CR 11 NOTIFICATION TO AUTHORITIES AND PRACTITIONER APPEAL RIGHT

When a MCO has taken actions against a practitioner for quality reasons, the organization offers a formal appeal process and reports the action to the appropriate authorities.

CR 11.1 The MCO has procedures for, and documentation of implementation, as appropriate, reporting of serious quality deficiencies that could result in a practitioner's suspension or termination to the appropriate authorities.

CR 11.2 The MCO has an appeal process for instances in which the MCO chooses to alter the condition of the practitioner's participation based on issues of quality of care and/or service. The MCO informs practitioners of the appeal process.

CR 12 ASSESSMENT OF ORGANIZATIONAL PROVIDERS

The MCO has written policies and procedures for the initial and ongoing assessment of organizational providers with which it intends to contract.

CR 12.1 The MCO includes at least the following medical providers:

CR 12.1.1 hospitals, home health agencies, skilled nursing facilities, nursing homes and free standing surgical centers;

CR 12.2 The MCO confirms that the provider is in good standing with the state and federal regulatory bodies and

CR 12.3 The MCO confirms that the provider has been reviewed and approved by an accrediting body, or

CR 12.4 If the provider has not been approved by an accrediting body, the MCO develops and implements standards of participation.

CR 12.5 At least every three years, the MCO confirms that the provider continues to be in good standing with state and federal regulatory bodies and, if applicable, is reviewed and approved by and accrediting body.

CR 13 DELEGATION OF CREDENTIALING

If the MCO delegates any credentialing and recredentialing activities, there is documentation of oversight of the delegated activity.

CR 13.1 A mutually agreed upon document describes:

CR 13.1.1 the responsibilities of the MCO and the delegated entity;

CR 13.1.2 the delegated activities;

CR 13.1.3 the process by which the MCO evaluates delegated entity's performance and

CR 13.1.4 the remedies, including revocation of the delegation, available to the MCO if the delegated entity does not fulfill its obligations.

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CR 13.2 The MCO retains the right, based on quality issues, to approve new practitioners, providers and sites and to terminate or suspend individual practitioner or providers.

CR 13.3 There is documentation that the MCO:

CR 13.3.1 evaluates the delegated entity's capacity to perform the delegated activities prior to delegation and

CR 13.3.2 evaluates annually whether the delegated entity's activities are being conducted in accordance with the MCO's expectations and NCQA standards.

MEMBERS' RIGHTS AND RESPONSIBILITIES

RR 1 STATEMENT OF MEMBERS RIGHTS AND RESPONSIBILITIES

The MCO has a written policy that states the organization's commitment to treating members in a manner that respects their rights as well as its expectations of members' responsibilities. This policy addresses the following rights and responsibilities:

RR 1.1 Members have a right to receive information about the MCO, its services, its practitioners and providers and members' rights and responsibilities.

RR 1.2 Members have a right to be treated with respect and recognition of their dignity and right to privacy.

RR 1.3 Members have a right to participate with practitioners in decision making regarding their health care.

RR 1.4 Members have a right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.

RR 1.5 Members have a right to voice complaints or appeals about MCO or the care provided.

RR 1.6 Members have a responsibility to provide, to the extent possible, information that the MCO and its practitioners and providers need in order to care for them.

RR 1.7 Members have a responsibility to follow the plans and instructions for care that they have agreed on with their practitioners.

RR 2 DISTRIBUTION OF RIGHTS STATEMENTS TO MEMBERS AND PRACTITIONERS

The MCO distributes the policy on members' rights and responsibilities to members and participating practitioners.

RR 3 POLICIES FOR COMPLAINTS AND APPEALS

The MCO has written policies and procedures for the thorough, appropriate and timely resolution of member complaints and appeals.

RR 3.1 Procedures for registering and responding to oral and written complaints include the following elements:

RR 3.1.1 documentation of the substance of the complaint and the actions taken;

RR 3.1.2 full investigation of the substance of the complaint, including any aspects of clinical care involved;

RR 3.1.3 notification to the member of the disposition of the complaint and the right to appeal, as appropriate, and

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RR 3.1.4 standards for timeliness in responding to complaints that accommodate the clinical urgency of the situation.

RR 4 SUBSCRIBER INFORMATION

The MCO provides each subscriber with information needed to understand benefit coverage and obtain care.

RR 4.1 The MCO provides written information about benefits and charges applicable to the subscriber. This information addresses the following elements:

RR 4.1.1 the benefits and services included in, and excluded from, coverage;

RR 4.1.1.1 this information states whether the MCO has pharmaceutical management procedures. It also describes how to obtain the procedures, the extent to which access to specific pharmaceuticals is restricted, and the process for requesting an exception to receive coverage for non-formulary pharmaceuticals if the MCO has a closed formulary.

RR 4.1.2 co-payments and other charges for which the member is responsible;

RR 4.1.3 any restrictions on benefits that apply to services obtained outside the MCO's system or outside the MCO's service area and

RR 4.2 The MCO provides written information that instructs members about how to obtain primary and specialty care. This includes the following:

RR 4.2.1 how to obtain information about practitioners who participate in the MCO;

RR 4.2.2 how to obtain primary care services, including points of access;

RR 4.2.3 how to obtain specialty care, behavioral health services and hospital services;

RR 4.2.4 how to obtain care after normal office hours;

RR 4.2.5 how too obtain emergency care, including the MCO's policy on when to directly access emergency care or use 911 services and

RR 4.2.6 how to obtain care and coverage when out of the MCO's service area.

RR 4.3 The MCO provides written information about:

RR 4.3.1 how to voice a complaint;

RR 4.3.2 how to appeal a decision that adversely affects the member's coverage, benefits or relationship to the organization and

RR 4.4 The MCO provides translation services within its member services telephone function based on the linguistic needs of its members

RR 5 PRIVACY AND CONFIDENTIALLY

The MCO protects the confidentiality of member information and records.

RR 5.1 The MCO adopts and implements written confidentiality policies and procedures to ensure the confidentiality of

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member information used for any purpose including policies for members who lack ability to give consent.

RR 5.2 The MCO contracts with practitioners and providers explicitly state expectations about the confidentiality of member information and records.

RR 5.3 The MCO ensures that data shared with employers, whether fully insured or self-insured, are not implicitly or explicitly member identifiable, unless specific consent is provided by members.

RR 6 MARKETING INFORMATION

The MCO ensures that communications with prospective members correctly and thoroughly represent the benefits and operating procedures of the organization.

RR 6.1 Materials for prospective members contain a summary statement of how UM procedures work.

RR 6.2 All materials and presentations accurately describe:

RR 6.2.1 the covered benefits, non-covered services, availability of practitioners and providers and potential restrictions incorporated in the MCO's operating procedures and

RR 6.2.2 the existence of pharmaceutical management procedures. The MCO informs members, upon request, how to obtain the procedures, the extent to which restricted pharmaceuticals are a covered benefit and the exceptions policy for receiving coverage for non-formulary pharmaceuticals if the MCO has a closed formulary.

RR 7 DELEGATION OF MEMBERS' RIGHTS AND RESPONSIBILITIES

If the MCO delegates any member services activities, there is evidence of oversight of the delegated activities.

RR 7.1 A mutually agreed upon document describes:

RR 7.1.1 the responsibilities of the MCO and the delegated entity;

RR 7.1.2 the delegated activities;

RR 7.1.3 the frequency of reporting to the MCO;

RR 7.1.4 the process by which the MCO evaluates the delegated entity's performance and

RR 7.1.5 the remedies, including revocation of the delegation, available to the MCO if the delegated entity does not fulfill its obligations.

RR 7.2 There is evidence that the MCO:

RR 7.2.1 evaluates the delegated entity's capacity to perform the delegated activities prior to delegation;

RR 7.2.2 evaluates regular reports as specified in RR 7.1.3 and

RR 7.2.3 evaluates annually whether the delegated entity's activities are being conducted in accordance with the MCO's expectations and NCQA standards.

PREVENTIVE HEALTH SERVICES

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PH 1 ADOPTION OF PREVENTIVE HEALTH GUIDELINES

The MCO has preventive health guidelines for prevention and early detection of illness and disease.

PH 1.1 The MCO has guidelines for the following categories:
Prenatal and perinatal care;
Preventive care for infants up to 24 months;
Preventive care for children and adolescents, 2-19 years;
Preventive care for adults, 20-64 years;
Preventive care for the elderly, 65 years and older.

PH 1.2 Each guideline describes the prevention or early detection interventions and the recommended frequency and conditions under which the interventions are required. The MCO documents the scientific basis or authority that it based the preventive health guidelines.

PH 1.3 Practitioners from the MCO who have appropriate knowledge have been involved in adoption of the preventive health guidelines.

PH 1.4 These preventive health guidelines or its predecessors have been available for use for at least two years.

PH 1.5 For those preventive health guidelines that have been in place for at least two years, there is evidence of review and update at least once every two years, where appropriate.

PH 2 DISTRIBUTION OF GUIDELINES TO PRACTITIONERS

The MCO distributes the preventive health guidelines and any updates to its practitioners.

PH 3 HEALTH PROMOTION WITH MEMBERS

The MCO regularly encourages its members to use preventive health services.

PH 3.1 The MCO distributes preventive health guidelines to members annually.

PH 3.2 The MCO informs and encourages members to use the health promotion, health education and preventive health services available.

PH 3.3 The MCO identifies specific members who, according to demographic and other identifiable health factors, may be at risk for specific health problems and urges these members to use appropriate health promotion and prevention services.

PH 4 DELEGATION OF PREVENTIVE HEALTH

If the MCO delegates any preventive health activities, there is evidence of oversight of the delegated activities.

PH 4.1 A mutually agreed upon document describes:

PH 4.1.1 the responsibilities of the MCO and the delegated entity;

PH 4.1.2 the delegated activities;

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PH 4.1.3 the frequency of reporting to the MCO;

PH 4.1.4 the process by which the MCO evaluates the delegated entity's performance and

PH 4.1.5 the remedies, including revocation of the delegation, available to the MCO if the delegated entity does not fulfill its obligations.

PH 4.2 There is evidence that the MCO:

PH 4.2.1 evaluates the delegated entity's capacity to perform the delegated activities prior to delegation;

PH 4.2.2 approves the delegated entity's preventive health work plan annually;

PH 4.2.3 evaluates regular reports as specified in PH 4.1.3 and

PH 4.2.4 evaluates annually whether the delegated entity's activities are being conducted in accordance with the MCO's expectations and NCQA standards.

MEDICAL RECORDS

MR 1 MEDICAL RECORDS DOCUMENTATION STANDARDS

The MCO requires medical records to be maintained in a manner that is current, detailed and organized and permits effective and confidential patient care and quality review.

MR 1.1 The MCO has medical record confidentiality policies and procedures.

MR 1.2 The MCO has medical record documentation standards, and these standards and goals are distributed to practice sites.

MR 1.3 The MCO establishes and requires its practitioners to have an organized medical record keeping system and standards for the availability of medical records appropriate to the practice site.

MR 1.4 The MCO has process to assess and improve, as needed, the quality of medical record keeping.

MR 2 COMPLIANCE WITH NCQA RECORDS STANDARDS

Documentation of items on the NCQA medical record review summary sheet demonstrates that medical records are in conformity with good professional medical practice and appropriate health management.

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EXHIBIT A-2
QUALITY IMPROVEMENT PROGRAM 2003 STANDARDS
PATIENT BILL OF RIGHTS (PBOR) AND COMPLAINTS

TIMELINESS OF UM DECISIONS

WAC 284-43-10(5)(b) Replaces UM 4.1.7.2	ongoing ambulatory care based on the severity or complexity of the patient's condition or on necessary treatment and discharge planning activity, but no more than 1 0 working days of obtaining all the necessary information/1/.
WAC 284-43-410(5)(d) Replaces UM 4.1.12	For retrospective review, the MCO notifies practitioners and members of denials in writing within two working days of making the decision./2/
	POLICIES FOR APPEALS
WAC 284-43-620(1) Replaces UM 7.1.4.2	If the MCO cannot make a decision within 14 days of receipt of the appeal, the carrier notifies the covered person that an extension is necessary to complete the appeal; however, the extension cannot delay the decision beyond thirty days of the request for appeal, without the informed, written consent of the covered person./3/
RCW 48.43.530(g) Replaces UM 7.1.5	written notification to the member of disposition of the appeal and of the potential right to appeal to a certified independent review organization (IRO)./4/
WAC 284-43-620(2) Replaces UM 7.1.6.2	The MCO makes the expedited appeal decision and notifies the member and practitioner(s) as expeditiously as the medical condition requires, but no later than three days after the request is made. If the treating provider determines that delay could jeopardize the covered person's health or ability to regain maximum function, the MCO shall presume the need for expeditious determination in any independent review./5/
WAC 284-43-620(4) Replaces UM 7.4	At least one of the people appointed to review an appeal involving clinical issues is an actively practicing practitioner in the same or a similar specialty who typically treats the medical condition, performs the procedure or provides the treatment. The individual did not participate in any of the MCO's prior decisions on the case.
WAC 284-43-630(1) Replaces UM 7.5.1	eligibility criteria stating that the MCO offers members the right to a certified IRO whenever:/6/
WAC 284-43-630(1) Replaces UM 7.5. 1.2	the MCO has completed one/7/ level of internal review and its decision is unfavorable to the member, or has elected to bypass/8/ internal review and proceed to the independent review or has exceeded its time limit for internal reviews, without good cause and without reaching a decision and
WAC 284-43-630(2)	A procedure for providing appropriate records or information to a certified IRO within 3 business days including:/9/
WAC 284-3-630(2)(a)	any medical records of the covered person relevant to the review;

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/1/ PBOR states that the frequency of the reviews for the extension of initial determinations must be based upon the severity or complexity of the patient's condition or on necessary treatment and discharge planning activity. See PBOR WAC 284-43-410 Utilization Review--Generally 5(b).
/2/ PBOR distinguishes different timelines for only concurrent review decisions i.e., "Notification of the determination shall be provided to the attending physician or ordering provider or facility and the covered person within two days of the determination and shall be provided within one day of concurrent review determination...." See PBOR WAC 284-43-410 Utilization Review--Generally 5(d).
/3/ See PBOR WAC 284-43-620(1) Procedures for review and appeal of adverse determinations for description of timelines. Timelines must conform with PBOR regulations unless NCQA standards more restrictive.
/4/ Deleted standards related to second level appeal; second level appeal is to an Independent Review Organization (IRO).
/5/ See PBOR WAC 284-43-620(2) Procedures for review and appeal of adverse determinations for description of expedited review. Also note the treating health care provider determines if delay could jeopardize health or ability to regain function.
/6/ Modified to comply with PBOR language, i.e., 'certified' independent review organization.
/7/ Modified from two levels of appeal to one level of appeal.
/8/ Removed reference to 'one or both levels'.
/9/ See PBOR WAC 284-43-630 (2) (a), (b), (c), (d), (e), (f) and (5) Independent review of adverse determinations.

WAC 284-43-630(2)(b)	any documents used by the MCO in making the determination to be reviewed by the certified IRO;
WAC 284-3-630(2)(C)	any documentation and written information submitted to the carrier in support of the appeal;
WAC 284-43-630(2)(d)	a list of each physician or health care provider who has provided care to the covered person and who may have medical records relevant to the appeal. Health information or other confidential or proprietary information in the custody of a carrier may be provided to an IRO, subject to the privacy provision of Title 284 WAC;
WAC 284-43-630(2)(e)	the attending or ordering provider's recommendations;
WAC 284-43-630(2)(f)	the terms and conditions of coverage under the relevant health plan. The MCO shall also make available to the covered person and to any provider acting on behalf of the covered person all materials provided to an IRO reviewing the MCO's determination.
	APPROPRIATE HANDLING OF APPEALS/10/
WAC 284-43-620 Replaces UM 8	The MCO adjudicates member's appeals in a thorough, appropriate and timely manner. The MCO meets all the requirements of standard UM 7, Patient Bill of Rights Legislation and its own standards for handling:
Replaces UM 8.1	first level appeals

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/10/ Modified to reflect Patient Bill of Rights Legislation and exclusion of second level appeals.

EXHIBIT B
WAC 388-538
MANAGED CARE

WAC 388-538-050
DEFINITIONS. The following definitions and abbreviations and those found in chapter 388-500-0005 WAC, Medical definitions, apply to this chapter.
"ANCILLARY HEALTH SERVICES" means health services ordered by a provider, including but not limited to, laboratory services, radiology services, and physical therapy.
"APPEAL" means a formal request by a provider or covered enrollee for reconsideration of a decision such as a utilization review recommendation, a benefit payment, an administrative action, or a quality of care or service issue, with the goal of finding a mutually acceptable solution.
"ASSIGN" or "ASSIGNMENT" means that MAA selects a managed care organization (MCO) or primary care case management (PCCM) provider to serve a client who lives in a mandatory enrollment area and who has failed to select an MCO or PCCM provider.
"BASIC HEALTH (BH)" means the health care program authorized by title 70.47 RCW and administered by the health care authority (HCA). MAA considers basic health to be third-party coverage, however, this does not include basic health plus (BH.+).
"CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)" means the health insurance program authorized by Title XXI of the Social Security Act and administered by the department of social and health services (DSHS). This program also is referred to as the state children's health insurance program (SCHIP).
"CHILDREN WITH SPECIAL HEALTH CARE NEEDS" means children identified by the department of social and health services (DSHS) as having special health care needs. This includes:
(1) Children designated as having special health care needs by the department of health (DOH) and served under the Title V program;
(2) Children who meet disability criteria of Title 16 of the Social Security Act (SSA); and
(3) Children who are in foster care or who are served under subsidized adoption.
"CLIENT" means an individual eligible for any medical program who is not enrolled with a managed care organization (MCO) or primary care case management (PCCM) provider. In this chapter, client refers to a person before the person is enrolled in managed care, while enrollee refers to an individual eligible for any medical program who is enrolled in managed care.
"COMPLAINT" means an oral or written expression of dissatisfaction by an enrollee.
"EMERGENCY MEDICAL CONDITION" means a condition meeting the definition in 42 U.S.C. 1396u-2(b)(2)(C).
"EMERGENCY SERVICES" means services as defined in 42 U.S.C. 1396u-2 (b)(2)(B).
"END ENROLLMENT" means an enrollee is currently enrolled in managed care, either with a managed care organization (MCO) or with a primary care case management (PCCM) provider, and requests to discontinue enrollment and return to the fee-for-service delivery system for one of the reasons outlined in WAC 388-538-130. This is also

referred to as "disenrollment."
"ENROLLEE" means an individual eligible for any medical program who is enrolled in managed care through a managed care organization (MCO) or primary care case management (PCCM) provider that has a contract with the state.
"ENROLLEES WITH CHRONIC CONDITIONS" means persons having chronic and disabling conditions, including persons with special health care needs that meet all of the following conditions:
(1) Have a biologic, psychologic, or cognitive basis;
(2) Have lasted or are virtually certain to last for at least one year; and
(3) Produce one or more of the following conditions stemming from a disease:
(a) Significant limitation in areas of physical, cognitive, or emotional function;
(b) Dependency on medical or assistive devices to minimize limitation of function or activities; or
(c) In addition, for children, any of the following:
(i) Significant limitation in social growth or developmental function;
(ii) Need for psychologic, educational, medical, or related services over and above the usual for the child's age; or
(iii) Special ongoing treatments, such as medications, special diet, interventions, or accommodations at home or school.
"EXEMPTION" means a client, not currently enrolled in managed care, makes a pre-enrollment request to remain in the fee-for-service delivery system for one of the reasons outlined in WAC 388-538-080.
"HEALTH CARE SERVICE" or "SERVICE" means a service or item provided for the prevention, cure, or treatment of an illness, injury, disease, or condition.
"HEALTHY OPTIONS CONTRACT OR HO CONTRACT" means the agreement between the department of social and health services (DSHS) and a managed care organization (MCO) to provide prepaid contracted services to enrollees.
"HEALTHY OPTIONS PROGRAM OR HO PROGRAM" means the medical assistance administration's (MAA) prepaid managed care health program for Medicaid-eligible clients and CHIP clients.
"MANAGED CARE" means a comprehensive system of medical and health care delivery including preventive, primary, specialty, and ancillary health services. These services are provided either through a managed care organization (MCO) or primary care case management (PCCM) provider.
"MANAGED CARE ORGANIZATION" or "MCO" means a health maintenance organization or health care service contractor that contracts with the department of social and health services (DSHS) under a comprehensive risk contract to provide prepaid health care services to eligible medical assistance administration (MAA) clients under MAA's managed care programs.
"NONPARTICIPATING PROVIDER" means a person or entity that does not have a written agreement with a managed care organization (MCO) but that provides MCO-contracted health care services to managed care enrollees with the authorization of the MCO. The MCO is solely responsible for payment for MCO-contracted health care services that are authorized by the MCO and provided by nonparticipating providers.

"PARTICIPATING PROVIDER" means a person or entity with a written agreement with a managed care organization (MCO) to provide health care services to managed care enrollees. A participating provider must look solely to the MCO for payment for such services.
"PRIMARY CARE CASE MANAGEMENT (PCCM)" means the health care management activities of a provider that contracts with the department to provide primary health care services and to arrange and coordinate other preventive, specialty, and ancillary health services.
"PRIMARY CARE PROVIDER (PCP)" means a person licensed or certified under Title 18 RCW including, but not limited to, a physician, an advanced registered nurse practitioner (ARNP), or a physician assistant who supervises, coordinates, and provides health services to a client or an enrollee, initiates referrals for specialist and ancillary care, and maintains the client's or enrollee's continuity of care.
"PRIOR AUTHORIZATION (PA)" means a process by which enrollees or providers must request and receive MAA approval for certain medical services, equipment, drugs, and supplies, based on medical necessity, before the services are provided to clients, as a precondition for provider reimbursement. Expedited prior authorization and limitation extension are forms of prior authorization. See WAC 388-501-0165.
"TIMELY" - in relation to the provision of services, means an enrollee has the right to receive medically necessary health care without unreasonable delay.

WAC 388-538-060
MANAGED CARE AND CHOICE.
(1) A client is required to enroll in managed care when that client meets all of the following conditions:
(a) Is eligible for one of the medical programs for which clients must enroll in managed care;
(b) Resides in an area, determined by the medical assistance administration (MAA), where clients must enroll in managed care;
(c) Is not exempt from managed care enrollment as determined by MAA, consistent with WAC 388-538-080, and any related fair hearing has been held and decided; and
(d) Has not had managed care enrollment ended by MAA, consistent with WAC 388-538-130.
(2) American Indian/Alaska Native (AI/AN) clients who meet the provisions of 25 U.S.C. 1603 (c)-(d) for federally-recognized tribal members and their descendants may choose one of the following:
(a) Enrollment with a managed care organization (MCO) available in their area;
(b) Enrollment with an Indian or tribal primary care case management (PCCM) provider available in their area; or
(c) MAA's fee-for-service system.
(3) A client may enroll with an MCO or PCCM provider by calling MAA's toll-free enrollment line or by sending a completed enrollment form to MAA.
(a) Except as provided in subsection (2) of this section for clients who are AI/AN and in subsection (5) of this section for cross-county enrollment, a client required to enroll in managed care must enroll with an MCO or PCCM provider available in the area where the client lives.

(b) All family members must either enroll with the same MCO or enroll with PCCM providers.
(c) Enrollees may request an MCO or PCCM provider change at any time.
(d) When a client requests enrollment with an MCO or PCCM provider, MAA enrolls a client effective the earliest possible date given the requirements of MAA's enrollment system. MAA does not enroll clients retrospectively.
(4) MAA assigns a client who does not choose an MCO or PCCM provider as follows:
(a) If the client has family members enrolled with an MCO, the client is enrolled with that MCO;
(b) If the client does not have family members enrolled with an MCO, and the client was enrolled in the last six months with an MCO or PCCM provider, the client is re-enrolled with the same MCO or PCCM provider;
(c) If a client does not choose an MCO or a PCCM provider, but indicates a preference for a provider to serve as the client's primary case provider (PCP), MAA attempts to contact the client to complete the required choice. If MAA is not able to contact the client in a timely manner, MAA documents the attempted contacts and, using the best information available, assigns the client as follows. If the client's preferred PCP is:
(i) Available with one MCO, MAA assigns the client in the MCO where the client's PCP provider is available. The MCO is responsible for PCP choice and assignment;
(ii) Available only as a PCCM provider, MAA assigns the client to the preferred provider as the client's PCCM provider;
(iii) Available with multiple MCOs or through an MCO and as a PCCM provider, MAA assigns the client to an MCO as described in (d) of this subsection;
(iv) Not available through any MCO or as a PCCM provider, MAA assigns the client to an MCO or PCCM provider as described in (d) of this subsection.
(d) If the client cannot be assigned according to (a), (b), or (c) of this subsection, MAA assigns the client as follows:
(i) If an AI/AN client does not choose an MCO or PCCM provider, MAA assigns the client to a tribal PCCM provider if that client lives in a zip code served by a tribal PCCM provider. If there is no tribal PCCM provider in the client's area, the client continues to be served by MAA's fee-for-service system. A client assigned under this subsection may request to end enrollment at any time.
(ii) If a non-AI/AN client does not choose an MCO or PCCM provider, MAA assigns the client to an MCO or PCCM provider available in the area where the client lives. The MCO is responsible for PCP choice and assignment. An MCO must meet the healthy options (HO) contract's access standards unless the MCO has been granted an exemption by MAA. The HO contract standards are as follows:
(A) There must be two PCPs within ten miles for ninety percent of HO enrollees in urban areas and one PCP within twenty-five miles for ninety percent of HO enrollees in rural areas;
(B) There must be two obstetrical providers within ten miles for ninety percent of HO enrollees in urban areas and one obstetrical provider within twenty-five miles for ninety percent of HO enrollees in rural areas;
(C) There must be one hospital within twenty-five miles for ninety percent of HO enrollees in the contractor's service area;

(D) There must be one pharmacy within ten miles for ninety percent of HO enrolles in urban areas and one pharmacy within twenty-five miles for ninety percent of HO enrollees in rural areas.
(iii) MAA sends a written notice to each household of one or more clients who are assigned to an MCO or PCCM provider. The notice includes the name of the MCO or PCCM provider to which each client has been assigned, the effective date of enrollment, the date by which the client must respond in order to change MAA's assignment, and either the toll-free telephone number of:
(A) The MCO for enrollees assigned to an MCO; or
(B) MAA for enrollees assigned to a PCCM provider.
(iv) An assigned client has at least thirty calendar days to contact MAA to change the MCO or PCCM provider assignment before enrollment is effective.
(5) A client may enroll with a plan in an adjacent county when the client lives in an area, designated by MAA, where residents historically have traveled a relatively short distance across county lines to the nearest available practitioner.
(6) An MCO enrollee's selection of the enrollee's PCP or the enrollee's assignment to a PCP occurs as follows:
(a) MCO enrollees may choose:
(i) A PCP or clinic that is in the enrollee's MCO and accepting new enrollees; or
(ii) Different PCPs or clinics participating with the same MCO for different family members.
(b) The MCO assigns a PCP or clinic that meets the access standards set forth in subsection (4)(d)(ii) of this section if the enrollee does not choose a PCP or clinic;
(c) MCO enrollees may change PCPs or clinics in an MCO at least once a year for any reason, and at any time for good cause; or
(d) In accordance with this subsection, MCO enrollees may file an appeal with the MCO and/or a fair hearing request with the department of social and health services (DSHS) and may change plans if the MCO denies an enrollee's request to change PCPs or clinics.

WAC 388-538-065
MEDICAID-ELIGIBLE BASIC HEALTH (BH) ENROLLEES.
(1) Certain children and pregnant women who have applied for, or are enrolled in, managed care through basic health (BH) (chapter 70.47 RCW) are eligible for Medicaid under pediatric and maternity expansion provisions of the Social Security Act. The medical assistance administration (MAA) determines Medicaid eligibility for children and pregnant women who enroll through BH.
(2) The administrative rules and regulations that apply to managed care enrollees also apply to Medicaid-eligible clients enrolled through BH, except as follows:
(a) The process for enrolling in managed care described in WAC 388-538-060(3) does not apply since enrollment is through the health care authority, the state agency that administers BH;
(b) American Indian/Alaska Native (AI/AN) clients cannot choose fee-for-service or PCCM as described in WAC 388-538-060(2). They must enroll in a BH-contracted MCO.

(c) If a Medicaid eligible client applying for BH does not choose an MCO within ninety days, the client is transferred from BH to the department of social and health services (DSHS) for assignment to managed care.

WAC 388-538-067
MANAGED CARE PROVIDED THROUGH MANAGED CARE ORGANIZATIONS (MCOs).
(1) Managed care organizations (MCOs) may contract with the department of social and health services (DSHS) to provide prepaid health care services to eligible medical assistance administration (MAA) clients under the healthy options (HO) managed care program. The MCOs must meet the qualifications in this section to be eligible to contract with DSHS. The MCO must:
(a) Have a certificate of registration from the office of the insurance commissioner (OIC) as either a health maintenance organization (HMO) or a health care services contractor (HCSC).
(b) Accept the terms and conditions of DSHS' HO contract;
(c) Be able to meet the network and quality standards established by DSHS; and
(d) Accept the prepaid rates published by DSHS.
(2) DSHS reserves the right not to contract with any otherwise qualified MCO.

WAC 388-538-068
MANAGED CARE PROVIDED THROUGH PRIMARY CARE CASE MANAGEMENT (PCCM).
(1) A provider may contract with DSHS as a primary care case management (PCCM) provider to provide health care services to eligible medical assistance administration (MAA) clients under MAA's managed care program. The PCCM provider or the individual providers in a PCCM group or clinic must:
(a) Have a core provider agreement with DSHS;
(b) Hold a current license to practice as a physician, certified nurse midwife, or advanced registered nurse practitioner in the state of Washington;
(c) Accept the terms and conditions of DSHS' PCCM contract;
(d) Be able to meet the quality standards established by DSHS; and
(e) Accept PCCM rates published by DSHS.
(2) DSHS reserves the right not to contract for PCCM with an otherwise qualified provider.

WAC 388-538-070
MANAGED CARE PAYMENT.
(1) The medical assistance administration (MAA) pays Managed care organizations (MCOs) monthly capitated premiums that:
(a) Have been determined using generally accepted actuarial methods based on analyses of historical healthy options (HO) contractual rates and MCO experience in providing health care for the populations eligible for HO; and
(b) Are paid based on legislative allocations for the HO program.
(2) MAA pays primary care case management (PCCM) providers a monthly case management fee according to contracted terms and conditions.
(3) MAA does not pay providers on a fee-for-service basis for services that are the MCO's responsibility under the HO contract, even if the MCO has not paid for the

service for any reason. The MCO is solely responsible for payment of MCO-contracted health care services:

(a) Provided by an MCO-contracted provider; or

(b) That are authorized by the MCO and provided by nonparticipating providers.

(4) MAA pays an additional monthly amount, known as an enhancement rate, to federally qualified health care centers (FQHC) and rural health clinics (RHC) for each client enrolled with MCOs through the FQHC or RHC. MCOs may contract with FQHCs and RHCs to provide services under HO. FQHCs and RHCs receive an enhancement rate from MAA on a per member, per month basis in addition to the negotiated payments they receive from the MCOs for services provided to MCO enrollees.

(a) MAA pays the enhancement rate only for the categories of service provided by the FQHC or RHC under the HO contact. MAA surveys each FQHC or RHC in order to identify the categories of services provided by the FQHC or RHC.

(b) MAA bases the enhancement rate on both of the following:

(i) The upper payment limit (UPL) for the county in which the FQHC or RHC is located; and

(ii) An enhancement percentage.

(c) MAA determines the UPL for each category of service based on MAA's historical fee-for-service (FFS) experience, adjusted for inflation and utilization changes.

(d) MAA determines the enhancement percentage for HO enrollees as follows: (i) For FQHCs, the enhancement percentage is equal to the FQHC finalized audit period ratio. The "finalized audit period" is the latest reporting period for which the FQHC has a completed audit approved by, and settled with, MAA.

(A) For a clinic with one finalized audit period, the ratio is equal to: (FQHC total costs) - FFS reimbursements .+ HO reimbursements)/(FFS .+ HO reimbursements).

(B) For a clinic with two finalized audit periods, the ratio is equal to the percentage change in the medical services encounter rate from one finalized audit period to the next. A "medical services encounter" is a face-to-face encounter between a physician or mid-level practitioner and a client to provide services for prevention, diagnosis, and/or treatment of illness or injury. A "medical services encounter rate" is the individualized rate MAA pays each FQHC to provide such services to clients, or the rate set by Medicare for each RHC for such services.

(C) For FQHCs without a finalized audit, the enhancement percentage is the statewide weighted average of all the FQHCs' finalized audit period ratios. Weighting is based on the number of enrollees served by each FQHC.

(ii) For RHCs, MAA applies the same enhancement percentage statewide.

(A) On a given month, MAA determines the number of HO enrollees enrolled with each RHC that is located in the same county as an FQHC. This number is expressed as a percentage of the total number of RHC enrollees located in counties that have both FQHCs and RHCs.

(B) For each county that has both an FQHC and an RHC, MAA multiplies the FQHC enhancement percentage, as determined under subsection (4)(d)(i) of this section, by the percentage obtained in section (4)(d)(ii)(A) of this section.

(C) The sum of all these products is the weighted statewide RHC enhancement percentage.

(iii) The HO enhancement percentage for FQHCs and RHCs is updated once a year.
(e) For each category of service provided by the FQHC or RHC, MAA multiplies the UPL, as determined under subsection (4)(c) of this section, by the FQHC's or RHC's enhancement percentage. The sum of all these products is the enhancement rate for the individual FQHC or RHC.
(f) To calculate the enhancement rate for FQHCs and RHCs that provide maternity and newborn delivery services, MAA applies each FQHC's or RHC's enhancement percentage to the delivery case rate (DCR), which is a one-time rate paid by MAA to the HO plan for each pregnant enrollee who gives birth.

WAC 388-538-080
MANAGED CARE EXEMPTIONS.
(1) The medical assistance administration (MAA) exempts a client from mandatory enrollment in managed care if MAA becomes aware of the following conditions. The client:
(a) Is receiving foster care placement services from the division of children and family services (DCFS); or
(b) Has Medicare, basic health (BH), CHAMPUS/TRICARE, or other accessible third-party health care coverage that would require exemption from enrollment with:
(i) A managed care organization (MCO) in accordance with MAA's healthy options (HO) contract requirements for MCO enrollment; or
(ii) A primary care case management provider (PCCM) in accordance with MAA's PCCM contract requirements for PCCM enrollment.
(2) Only a client or a client's representative (RCW 7.70.065) may request an exemption from managed care enrollment for reasons other than those stated in subsection (1) of this section. If a client asks for an exemption prior to the enrollment effective date, the client is not enrolled until MAA approves or denies the request and any related fair hearing is held and decided.
(3) MAA grants a client's request for an exemption from mandatory enrollment in managed care if any of the following apply:
(a) The client has a documented and verifiable medical need to continue a client/provider relationship due to an established course of care with a physician, physician assistant or advanced registered nurse practitioner. MAA accepts the established provider's signed statement that the client has:
(i) A medical need that requires a continuation of the established care relationship; and
(ii) The client's established provider is not available through any managed care organization (MCO) or as a primary care case management (PCCM) provider.
(b) Prior to enrollment, the client scheduled a surgery with a provider not available to the client through managed care and the surgery is scheduled within the first thirty days of enrollment; or
(c) The client is American Indian/Alaska Native (AI/AN) as specified in WAC 388-538- 060(2) and requests exemption; or
(d) The client has been identified by MAA as having special needs that meet MAA's definition of children with special health care needs and requests exemption; or
(e) The client is pregnant and wishes to continue her established course of prenatal care with an obstetrical provider who is not available to her through managed care; or

(f) On a case-by-case basis, the client presents evidence that managed care does not provide medically necessary care that is reasonably available and accessible as offered to the client. MAA considers that medically necessary care is not reasonably available and accessible when any of the following apply:
(i) The client is homeless or is expected to live in temporary housing for less than one hundred twenty days from the date the client requests the exemption;
(ii) The client speaks limited English or is hearing impaired and the client can communicate with a provider who communicates in the client's language or in American Sign Language and is not available through managed care;
(iii) The client shows that travel to a managed care PCP is unreasonable when compared to travel to a non-managed care primary care provider (PCP). This is shown when any of the following transportation situations apply to the client:
(A) It is over twenty-five miles one-way to the nearest managed care PCP who is accepting enrollees, and the client's PCP is closer and not in an available plan;
(B) The travel time is over forty-five minutes one-way to the nearest managed care PCP who is accepting enrollees, and the travel time to the client's PCP, who is not available in an MCO or as a PCCM provider, is less;
(C) Other transportation difficulties make it unreasonable to get primary medical services under HO; or
(iv) Other evidence is presented that an exemption is appropriate based on the client's circumstances, as evaluated by MAA.
(4) MAA exempts the client for the time period the circumstances or conditions that led to the exemption are expected to exist. If the request is approved for a limited time, the client is notified in writing or by telephone of the time limitation, the process for renewing the exemption, and the client's fair hearing rights.
(5) The client is not enrolled as provided in subsection (2) of this section and receives timely notice by telephone or in writing when MAA approves or denies the client's exemption request. If initial denial notice was by telephone, then MAA gives the reasons for the denial in writing before requiring the client to enroll in managed care. The written notice to the client contains all of the following:
(a) The action MAA intends to take, including enrollment information;
(b) The reason(s) for the intended action;
(c) The specific rule or regulation supporting the action;
(d) The client's right to request a fair hearing, including the circumstances under which the fee-for-service status continues, if a hearing is requested; and
(e) A translation into the client's primary language when the client has limited English proficiency.

WAC 388-538-095
SCOPE OF CARE FOR MANAGED CARE ENROLLEES.
(1) Managed care enrollees are eligible for the scope of medical care as described in WAC 388-529-0100 for categorically needy clients.
(a) A client is entitled to timely access to medically necessary services as defined in WAC 388-500-0005.

(b) The managed care organization (MCO) covers the services included in the healthy options (HO) contract for MCO enrollees. In addition, MCOs may, at their discretion, cover services not required under the HO contract.
(c) The medical assistance administration (MAA) covers the categorically needy services not included in the HO contract for MCO enrollees.
(d) MAA covers services on a fee-for-service basis for enrollees with a primary care case management (PCCM) provider. Except for emergencies, the PCCM provider must either provide the covered services needed by the enrollee or refer the enrollee to other providers who are contracted with MAA for covered services. The PCCM provider is responsible for instructing the enrollee regarding how to obtain the services that are referred by the PCCM provider. The services that require PCCM provider referral are described in the PCCM contract. MAA informs enrollees about the enrollee's program coverage, limitations to covered services, and how to obtain covered services.
(e) MCO enrollees may obtain certain services from either a MCO provider or from a medical assistance provider with a DSHS core provider agreement without needing to obtain a referral from the PCP or MCO. These services are described in the HO contract, and are communicated to enrollees by MAA and MCOs as described in (f) of this subsection.
(f) MAA sends each client written information about covered services when the client is required to enroll in managed care, and any time there is a change in covered services. This information describes covered services, which services are covered by MAA, and which services are covered by MCOs. In addition, MAA requires MCOs to provide new enrollees with written information about covered services.
(2) For services covered by MAA through PCCM contracts for managed care:
(a) MAA medically necessary covers services included in the categorically needy scope of care and rendered by providers with a current department of social and health services (DSHS) core provider agreement to provide the requested service;
(b) MAA may require the PCCM provider to obtain authorization from MAA for coverage of nonemergency services;
(c) The PCCM provider determines which services are medically necessary;
(d) An enrollee may request a fair hearing for review of PCCM provider or MAA coverage decisions; and
(e) Services referred by the PCCM provider require an authorization number in order to receive payment from MAA.
(3) For services covered by MAA through contracts with MCOs:
(a) MAA requires the MCO to subcontract with a sufficient providers to deliver the scope of contracted services in a timely manner. Except for emergency services, MCOs provide covered services to enrollees through their participating providers;
(b) MAA requires MCOs to provide new enrollees with written information about how enrollees may obtain covered services;
(c) For nonemergency services, MCOs may require the enrollee to obtain a referral from the primary care provider (PCP), or the provider to obtain authorization from the MCO, according to the requirements of the HO contract;
(d) MCOs and their providers determine which services are medically necessary given the enrollee's condition, according to the requirements included in the HO contract;

(e) An enrollee may appeal an MCO coverage decisions using the MCO's appeal process, as described in WAC 388-538-0110. An enrollee may also request a hearing for review of an MCO coverage decision as described in chapter 388-02 WAC;
(f) A managed care enrollee does not need a PCP referral to receive women's health care services, as described in RCW 48.42.100 from any women's health care provider participating with the MCO. Any covered services ordered and/or prescribed by the women's health care provider must meet the MCO's service authorization requirements for the specific service.
(4) Unless the MCO chooses to cover these services, or an appeal or a fair hearing decision reverses an MCO or MAA denial, the following services are not covered:
(a) For all managed care enrollees:
(i) Services that are not medically necessary;
(ii) Services not included in the categorically needy scope of services; and
(iii) Services, other than a screening exam as described in WAC 388-538-100(3), received in a hospital emergency department for nonemergency medical conditions.
(b) For MCO enrollees:
(i) Services received from a participating specialist that require prior authorization from the MCO, but were not authorized by the MCO; and
(ii) Services received from a nonparticipating provider that require prior authorization from the MCO that were not authorized by the MCO. All nonemergency services covered under the HO contract and received from nonparticipating providers require prior authorization from the MCO.
(c) For PCCM enrollees, services that require a referral from the PCCM provider as described in the PCCM contract, but were not referred by the PCCM provider.
(5) A provider may bill an enrollee for noncovered services as described in subsection (4) of this section, if the enrollee and provider sign an agreement. The provider must give the original agreement to the enrollee and file a copy in the enrollee's record.
(a) The agreement must state all of the following:
(i) The specific service to be provided;
(ii) That the service is not covered by either MAA or the MCO;
(iii) An explanation of why the service is not covered by the MCO or MAA, such as:
(A) The service is not medically necessary; or
(B) The service is covered only when provided by a participating provider,
(iv) The enrollee chooses to receive and pay for the service; and
(v) Why the enrollee is choosing to pay for the service, such as:
(A) The enrollee understands that the service is available at no cost from a provider participating with the MCO, but the enrollee chooses to pay for the service from a provider not participating with the MCO;
(B) The MCO has not authorized emergency department services for nonemergency medical conditions and the enrollee chooses to pay for the emergency department's services rather than wait to receive services at no cost in a participating provider's office; or
(C) The MCO or PCCM has determined that the service is not medically necessary and the enrollee chooses to pay for the service.
(b) For limited English proficient enrollees, the agreement must be translated or interpreted into the enrollee's primary language to be valid and enforceable.

(c) The agreement is void and unenforceable, and the enrollee is under no obligation to pay the provider, if the service is covered by MAA or the MCO as described in subsection (1) of this section, even if the provider is not paid for the covered service because the provider did not satisfy the payor's billing requirements.

WAC 388-538-100
MANAGED CARE EMERGENCY SERVICES.
(1) A managed care enrollee may obtain emergency services, for emergency medical conditions in any hospital emergency department. These definitions differ from the emergency services definition that applies to services covered under the medical assistance administration's (MAA's) fee-for-service system.
(a) The managed care organization (MCO) covers emergency services for MCO enrollees.
(b) MAA covers emergency services for primary care case management (PCCM) enrollees.
(2) Emergency services for emergency medical conditions do not require prior authorization by the MCO, primary care provider (PCP), PCCM provider, or MAA.
(3) Emergency services received by an MCO enrollee for nonemergency medical conditions must be authorized by the plan for enrollee's MCO.
(4) An enrollee who requests emergency services is entitled to receive an exam to determine if the enrollee has an emergency medical condition.

WAC 388-538-110
MANAGED CARE COMPLAINTS, APPEALS, AND FAIR HEARINGS.
(1) A managed care enrollee has the right to voice a complaint or submit an appeal of an MAA, MCO, PCCM, PCP or provider decision, action, or inaction. An enrollee may do this through the following process:
(a) For managed care organization (MCO) enrolles, the MCO's complaint and appeal processes, and through the department's fair hearing process; or
(b) For primary care case management (PCCM) enrollees, the complaint and appeal processes of the medical assistance administration (MAA), and through the department's fair hearing process (chapter 388-02 WAC).
(2) To ensure the rights of MCO enrollees are protected, MAA approves each MCO's complaint and appeal policies and procedures annually or whenever the plan makes a change to the process.
(3) MAA requires MCOs to inform MCO enrollees in writing within fifteen days of enrollment about their rights and how to use the MCO's complaint and appeal processes. MAA requires MCOs to obtain MAA approval of all written information sent to enrollees.
(4) MAA provides PCCM enrollees with information equivalent to that described in subsection (3) of this section.
(5) MCO enrollees may request assistance from the MCO when using the MCO's complaint and appeals processes. PCCM enrollees may request assistance from MAA when using MAA's complaint and appeal process.

(6) An MCO enrollee who submits a complaint under this section is entitled to a written or verbal response from the MCO or from MAA within the timeline in the MAA-approved complaint process.
(7) When an enrollee is not satisfied with how the complaint is resolved by the MCO or by MAA, or if the complaint is not resolved in a timely fashion, the enrollee may submit an appeal to the MCO or to MAA. An enrollee may also appeal an MAA, MCO, primary care provider (PCP), or provider decision, or reconsideration of any action or inaction. An enrollee who appeals an MAA, MCO, PCP, or provider decision is entitled to all of the following:
(a) A review of the decision being appealed. The review must be conducted by an MCO or MAA representative who was not involved in the decision under appeal;
(b) Continuation of the service already being received and which is under appeal, until a final decision is made;
(c) A written decision from MAA or the MCO, within the timeline(s) in the appeal process standards, in the enrollee's primary language. The decision does not need to be translated if an enrollee with limited English proficiency prefers correspondence in English, and the deciding authority documents the enrollee's preference. The notice must clearly explain all of the following:
(i) The decision and any action MAA or the MCO intends to take;
(ii) The reason for the decision;
(iii) The specific information that supports MAA's or the MCO's decision; and
(iv) Any further appeal or fair hearing rights available to the enrollee, including the enrollee's right to continue receiving the service under appeal until a final decision is made.
(d) An expedited decision when it is necessary to meet an existing or anticipated acute or urgent medical need.
(8) An enrollee may file a fair hearing request without also filing an appeal with MAA or the MCO or exhausting MAA's or the MCO's appeal process.
(9) The MCO's medical director or designee reviews all fair hearings requests, and any related appeals, when the issues involve an MCO's determination of medical necessity.
(10) MAA's medical director or the medical director's designee reviews all fair hearings requests, and any related appeals, when the PCCM enrollee's issues involve an MAA determination of medical necessity.

WAC 388-538-120
ENROLLEE REQUEST FOR A SECOND MEDICAL OPINION.
(1) A managed care enrollee has the right to a timely referral for a second opinion upon request when:
(a) The enrollee needs more information about treatment recommended by the provider or managed care organization (MCO); or
(b) The enrollee believes the MCO is not authorizing medically necessary care.
(2) A managed care enrollee has a right to a second opinion from a primary or specialty care physician who is participating with the MCO. At the MCO's discretion, a clinically appropriate nonparticipating provider who is agreed upon by the MCO and the enrollee may provide the second opinion.

(3) Primary care case management (PCCM) provider enrollees have a right to a timely referral for a second opinion by another provider who has a core provider agreement with medical assistance administration (MAA).

WAC 388-538-130
ENDING ENROLLMENT IN MANAGED CARE.

(1) MAA ends an enrollee's enrollment in a managed care organization (MCO) or with a primary care case management (PCCM) provider when the enrollee meets any of the following conditions. The enrollee:
(a) Is no longer eligible for a medical program subject to enrollment; or
(b) Is receiving foster care placement services from the division of children and family services; or
(c) Is or becomes eligible for Medicare, basic health (BH), CHAMPUS/TRICARE, or any other accessible third party health care coverage that would require involuntary disenrollment from:
(i) An MCO in accordance with MAA's healthy options (HO) contract for MCO enrollees; or
(ii) A PCCM provider in accordance with MAA's PCCM contract for PCCM enrollees.
(2) An enrollee or the enrollee's representative as defined in RCW 7.70.065 may request MAA to end enrollment as described in subsections (3) through (10) of this section. A managed care organization (MCO) may request MAA to end enrollment for an enrollee as described in subsection (11) of this section. Only MAA has authority to remove an enrollee from managed care. Pending MAA's final decision, the enrollee remains enrolled unless staying in managed care would adversely affect the enrollee's health status.
(3) MAA grants an enrollee's request to have the enrollee's enrollment ended under the following conditions:
(a) Is American Indian or Alaska Native (AI/AN) and requests disenrollment; or
(b) Is identified by DSHS as a child who meets the definition of "children with special health care needs" and requests disenrollment.
(4) MAA grants an enrollee's requests to be removed from managed care when the client is pregnant or when there is a verified medical need to continue an established course of care. These end enrollments are limited to the following situations: The enrollee:
(a) Has a documented medical need to continue a client/provider relationship due to an established course of care with a physician, physician assistant, or advanced registered nurse practitioner. The standards for documenting a medical need are those in WAC 388-538-080(3)(a). The established course of care must begin:
(i) While the enrollee was enrolled with managed care but the PCP is no longer available to the enrollee under managed care; or
(ii) Prior to enrollment in managed care and the PCP is not available under any MCO or as a PCCM provider.
(b) Is pregnant and requests to continue her course of prenatal care that was established with an obstetrical provider:
(i) While she was enrolled with the MCO but that provider is no longer available to her in managed care; or

(ii) Prior to enrollment with the current MCO but that provider is not available to her under managed care.
(c) Is scheduled for a surgery with a provider not available to the enrollee in the enrollee's current MCO and the surgery is scheduled to be performed within the first thirty days of enrollment.
(5) Except as provided in subsection (4) of this section, MAA does not permit an enrollee to obtain an end enrollment by establishing a course of care with a provider who is not participating with the enrollee's MCO.
(6) MAA ends enrollment on a case-by-case basis when the enrollee presents evidence that the managed care program does not provide medically necessary care that is reasonable available and accessible as offered to the enrollee. MAA considers enrollee requests under this subsection with the same criteria as listed in WAC 388-538-080(3)(f).
(7) MAA ends enrollment temporarily if an enrollee asks to be taken out of the current MCO in order to stay with the enrollee's established provider, but is willing to enroll in the established provider's MCO for the next enrollment month. MAA reviews the enrollee request according to the criteria in subsections (4) and (6) of this section. MAA's decision under this subsection include all of the following:
(a) The decision is given verbally and in writing;
(b) Verbal and written notices include the reason for the decision and information on hearings so the enrollee may appeal the decision;
(c) If the request to end enrollment is approved, it may be effective back to the beginning of the month the request is made; and
(d) If the request to end enrollment is denied, and the enrollee requests a hearing; the enrollee remains in the MCO or with the PCCM until the hearing decision is made as provided in subsection (2) of this section.
(8) MAA ends enrollment for the period of time the circumstances or conditions that led to ending the enrollment are expected to exist. If the request to end enrollment is approved for a limited time, the client is notified in writing or by telephone of the time limitation, the process for renewing the disenrollment, and their fair hearing rights.
(9) MAA does not approve an enrollee's request to end enrollment solely to pay for services received but not authorized by the MCO.
(10) The enrollee remains in managed care as provided in subsection (1) of this section and receives timely notice by telephone or in writing when MAA approves or denies the enrollee's request to end enrollment. Except as provided in subsection (7) of this section, MAA gives the reasons for a denial in writing. The written denial notice to the enrollee contains all of the following:
(a) The action MAA intends to take;
(b) The reason(s) for the intended action;
(c) The specific rule or regulation supporting the action;
(d) The enrollee's right to request a fair hearing; and
(e) A translation into the enrollee's primary language when the enrollee has limited English proficiency.
(11) MAA may end an enrollee's enrollment in a MCO or with a PCCM provider when the enrollee's MCO or PCCM provider substantiates in writing, to MAA's satisfaction, that:

(a) The enrollee's behavior is inconsistent with the MCO or PCCM provider rules and regulations, such as intentional misconduct; and
(b) After the MCO or PCCM provider has provided:
(i) Clinically appropriate evaluation(s) to determine whether there is a treatable problem contributing to the enrollee's behavior; and
(ii) If so, has provided clinically appropriate referral(s) and treatment(s), but the enrollee's behavior continues to prevent the provider from safely or prudently providing medical care to the enrollee; and
(c) The enrollee received written notice from the MCO or PCCM provider of the MCO or PCCM provider intent to request the enrollee's removal, unless MAA has waived the requirement for the MCO or PCCM provider notice because the enrollee's conduct presents the threat of imminent harm to others. The MCO or PCCM provider notice to the enrollee must include both of the following:
(i) The enrollee's right to use the appeal process as described in WAC 388-538-110 to review the MCO or PCCM provider request to end the enrollee's enrollment; and
(ii) The enrollee's right to use the department fair hearing process.
(12) MAA makes a decision to remove an enrollee from enrollment in managed care within thirty days of receiving the MCO or PCCM provider request to do so. Before making a decision, MAA attempts to contact the enrollee and learn the enrollee's perspective. If MAA approves the MCO or PCCM provider request to remove the enrollee, MAA sends a notice at least ten days in advance of the effective date that enrollment will end. The notice includes the reason for MAA's approval to end enrollment and information about the enrollee's fair hearing rights.
(13) MAA does not approve a request to remove an enrollee from managed care when the request is solely due to an adverse change in the enrollee's health or the cost of meeting the enrollee's needs.

WAC 388-538-140
QUALITY OF CARE.
(1) In order to assure that managed care enrollees receive appropriate access to quality health care and services, the medical assistance administration (MAA) does all of the following:
(a) Requires managed care organizations (MCOs) to have a fully operational quality assurance system that meets a comprehensive set of quality improvement program (QIP) standards.
(b) Monitors MCO performance through on-site visits and other audits, and requires corrective action for deficiencies that are found.
(c) Requires MCOs to report annually on standardized clinical performance measures that are specified in the contract with MAA, and requires corrective action for substandard performance.
(d) Contracts with a professional review organization to conduct independent external review studies of selected health care and service delivery.
(e) Conducts enrollee satisfaction surveys.

(f) Annually publishes individual MCO performance information and primary care case management (PCCM) program performance information including certain clinical measures and enrollee satisfaction surveys and makes reports of site monitoring visits available upon request.

(2) MAA requires MCOs and PCCM providers to have a method to assure consideration of the unique needs of enrollees with chronic conditions. The method includes:

(a) Early identification;

(b) Timely access to health care; and

(c) Coordination of health service delivery and community linkages.

EXHIBIT C-1
2003 HEALTHY OPTIONS & SCHIP
ENCOUNTER DATA SPECIFICATIONS

PREFACE

Healthy Options & SCHIP encounter data is used for many purposes. Among these are federal reporting to the Medicaid Statistical Information System (MSIS); HO & SCHIP rate setting and risk adjustment; Medical Assistance Administration's (MAA) hospital rate setting; the HO & SCHIP quality improvement program, and research. To ensure the efficient and timely collection of quality encounter data for these purposes 2003 encounter data specifications are as follows:

GENERAL FILE REQUIREMENTS

1) The Contractor shall submit encounter data in accordance with the 2003 HO & SCHIP Encounter Data Specifications. These specifications apply to adjudicated and capitated encounter records. Adjudicated encounter records include those that the Contractor paid as well as those for which the Contractor denied payment.

2) The Contractor shall submit all encounter records no later than 450 calendar days following the date of service for the encounters reported.

3) The Contractor shall submit all finalized, not previously submitted encounter records that the Contractor processed during the reporting quarter by the specified encounter data submission date which is 90 calendar days after the end of the reporting quarter.

4) The Contractor shall submit a "roll up" of any adjustments made to an encounter record into a single encounter record for initial submission.

5) MAA may reject files exceeding 2% overall error rate.

6) The Contractor shall correct rejected encounter records and include these with a complete resubmission of all records pertinent to the reporting quarter. Resubmissions are due no later than 90 calendar days after receiving them back from DSHS. After this date encounter records are still required to be submitted but shall be considered late.

7) The Contractor must assign the services and codes to the associated encounter type specified in the associated MAA 'fee-for-service' Billing Instructions (e.g. for Physician Related Services, that is current on the date of service). Examples of the encounter type associated with some commonly used procedures are given in the Encounter Type Table. Contractors may use 'J' (medical practitioner) and 'L' (EPSDT) designations on different records of the same encounter when both types of services were provided.

8) Excluding inpatient hospital (R) encounter type, "Date of Service" in these specifications

means the day the enrollee received the service. For inpatient hospital (R) encounters, "Date of Service" means the date of discharge. Except for inpatient hospital services, the Contractor must report services provided on different dates as separate encounters. This includes professional medical services provided in a hospital setting.

9) The Contractor may submit encounters by contract type (HO/SCHIP and Basic Health Plus) in a single file. The Plan ID (Field 6) assigned to a record must reflect the contract under which the member is enrolled on the date of service.

10) The Contractor must use the Contractor's Plan ID (Field 6) in encounter records when enrollees receive care through an FQHC or RHC.

11) Procedure code modifiers are required for outpatient hospital (M) services (reported on the federal HCFA/CMS UB-92 form) as well as for medical professional (J), EPSDT (L), and (P) encounters (reported on HCFA/CMS 1500 form).

12) EPSDT Referral Indicator (Field 24) is a required field. The associated error flag will be tracked separately by EDU. Related errors will be excluded from the total count and percentage of records otherwise with errors. Blank-fill Field 24 if the EPSDT indicator cannot be obtained. The contractor is required to report the encounter even though the blank fill will result in an error during the MAA edit process.

13) Contractors submitting alternative identifiers (Field 38 and 39) shall submit, with each quarterly submission, a separate file list that enables MAA to link the alternative identifier with the identity of the provider.

14) Contractors must meet new, additional, or revised requirements of the federal Health Insurance Portability and Accountability Act (HIPAA) that may take affect during the contract period.

15) MAA reserves the right to:

a) Modify any encounter data reporting requirement following 120 calendar days notice to the Contractor;

b) Request data substantiating reported encounter records following at least 30 calendar days notice to the Contractor; and

c) Waive encounter data requirements under exceptional circumstances with written approval from MAA.

SCHEDULE

The HO/SCHIP 2003 encounter data requirements are effective with data collected on or after January 1, 2003.

REPORTING QUARTER: The quarter in which the encounter records were processed by the Contractor for initial submission. The submission is due no later than 90 calendar days after the last day of the reporting quarter.

REPORTING QUARTER	REPORTING QUARTER	SUBMISSION DATE
Q3-02	July 1 through September 30, 2002	January 2, 2003
Q4-02	October 1 through December 31, 2002	April 1, 2003
Q1-03	January 1 through March 31, 2003	July 1, 2003
Q2-03	April 1 through June 30, 2003	October 1, 2003
Q3-03	July 1 through September 30, 2003	January 2, 2004
Q4-03	October 1 through December 31, 2003	April 1, 2004

SUBMISSION MEDIA SPECIFICATIONS

1) When submitting compact disk or computer diskette, submit fixed width text files. Do not include internal labels. For compact disk, computer diskette, and tape include:

   Data Set Name format: MCED.Ppppppp.YyyQTRq

MCED	A literal value abbreviation for "Managed Care Encounter Data"
P	A literal prefix
ppppppp	The Contractor's Medicaid Provider Number
Y	A literal prefix
yy	The last two digits of the calendar year reported
QTR	A literal value
q	The calendar quarter reported (see Schedule of Submissions)

2) For submissions on magnetic tape:

   Write encounter data file to an IBM OS standard labeled tape (8 1/2 or 10 1/2 inches) in EBCDIC:

   RECFM=FB
   BLKSIZE=30000
   LRECL=500
   DENSITY=1600BPI or 6250 BPI

TEST FILES

1) Contractors may submit a compact disk, computer diskette, or tape containing test data (2000-3000 records) to identify and resolve errors and problems with field definitions.

2) Records representing all encounter types covered by the contract should be included.

3) Identify the file as a "test" at the time of submission.

EXTERNAL LABEL AND SHIPPING/MAILING ADDRESS

1) Submit initial encounter records in a file separate from file(s) containing adjusted, corrected and/or voided encounter records.

2) Attach an external label for each file contained on the tape, compact disk, and computer diskette including at least the following information:

- o Plan name
- o File name: Specify content: 1) "initial submission" or; 2) "complete resubmission (i.e. encounters pertaining to previous submissions)
- o Logical record length
- o Year and quarter reported
- o Program(s) i.e., Healthy Options, BHP Plus, or both
- o Specify whether the compact disk, computer diskette, or tape contains records for some encounter types (for example, pharmacy only) or all encounter types
- o Block size (needed only for submissions on tape)
- o Number of records per file

3) Send to:
Encounter Data Coordinator
Information Services Division
DSHS Medical Assistance Administration
617 8th Avenue SE, Bldg. 1, 4th Fl.
P.O. Box 45511
Olympia, WA 98504-5511

Direct questions and comments to the Encounter Data Coordinator at (360) 725-1288.

ERROR REPORT

The Encounter Data Unit will provide a report evaluating timely reported encounter data submissions. In addition, error flags will be placed in each record during MAA's edit of the record to assist the Contractor in the identification of problem areas.

Contractors must prevent reoccurrence of the same type of errors in subsequent submissions. If the same type of errors reoccur, DSHS may return the incorrect encounter submission.

NOTE: To permit error flags to be written to an encounter data tape, the Tape Label EXPIRATION DATE must either be eliminated or set at a date at least six months after the date of submission.

GENERIC FIELD SPECIFICATIONS

1) NUMERIC FIELDS

- RIGHT justify (data)

- ZERO fill (from left)

- EIGHT fill when:
  - Not applicable to the encounter type. Examples: (1) Eight-fill the hospital discharge date for all encounter types, excluding inpatient hospital (R). (2) Eight-fill the revenue code (Field 21) for outpatient hospital encounters when a procedure code is reported in Field 16 not IP.

    -OR-

  - Applicable but not required and for which there is no data. Example: When a Contractor is unable to obtain a Medicaid Billing Provider Number of a pharmacy, it may eight-fill Field 7 and report a NAPB Identifier or Federal Tax Identifier as the alternate Billing Provider Identification in Field 38.

- NINE fill when valid entries are required but unknown. Nine-filling is required, but unknown numeric data will result in an error. Nine-fill only when the required information cannot be supplied within reporting deadlines.

- DATE FORMAT - MMDDYY (DSHS edits provide for identifying century)

- DECIMAL POINTS - DSHS edits assume decimal points except for Fields 16, 17, 19 and 20. For these four fields, the decimal points are to be inserted as required by the appropriate coding systems.

2) CHARACTER FIELDS

- LEFT justify (data)

- BLANK fill (from right) when
  - valid entries are required but unknown. Blank-filling required but unknown character fields will result in an error. Blank-fill only when there is a need to meet time requirements for reporting encounter events. Example: An EPSDT Referral Indicator is unknown. Blank-fill Field 24. The Contractor is required to report the encounter even though the Blank-fill will result in an error during the MAA edit process.

- HYPHEN ('-') fill when
  - not applicable, OR
  - applicable but not required and for which there is no data. Example: A hospital reports an inpatient stay and there are only 2 diagnosis codes. Hyphen-fill diagnoses 3 through

9 since there are no diagnoses to report.

VALIDATION EDITS

DSHS will perform edits on all submitted encounter data files. If an invalid result is found, it may be treated as an 'error' and included in the count of records with errors or it may be the result of an 'association check' and reported as 'information only'.

ERRORS: The edits that will identify the following conditions as errors pertain to the required fields:

1. Missing (required) values
2. Non-numeric data in numeric fields
3. Negative values in numeric fields
4. Invalid dates
5. Invalid values for:

FIELD NAME	FIELD NUMBER
Encounter Type	1
Line Item Number	3
Recipient ID/PIC	4
Billing and Performing/Attending or Prescribing Provider ID (Billing ID may be a Medicaid #, Tax ID, or for pharmacies NABP#; Performing/Attending or Prescribing ID may be a Medicaid #, State License #, or DEA #)	7,8,38 & 39
DRG	9
Place of Service	15
Procedure Code	16 & 17
Procedure Code Modifier	18
Diagnosis Code	19 & 20
Revenue Codes	21
National Drug Code	22
EPSDT Referral Code Tracked separately and not included in count and percentage of records otherwise with errors.	24
Plan Record ID	25
Prescription Number	27
Claim Status	28
Line Status	29
Patient Control Number	41
Prescription Days Supply	88
Alternate Bill-Provider ID Type	90
Alternate Perf-Attend-Presc ID Type	91

6. EPSDT encounters with incorrect procedure codes or age greater than 20.

7. Records for the same encounter containing different encounter type designations, except J and L Encounter Type designations that may occur on different records for the exact same encounter.

8. Other conditions occurring due to improperly following encounter data specifications may also be evaluated.

ASSOCIATION CHECKS: Edits of the association between two fields will check for invalid recipient age or sex for diagnosis or procedure, and recipient eligibility and provider Medicaid number active status for the dates of service. Counts of inconsistent associations will be indicated by the prefix' * ' on the hard copy of error summary reports and will not be included in the counts of errors.

PHYSICAL RECORD LAYOUT AND FIELD REQUIREMENTS

KEY FOR ENCOUNTER TYPE CODES	
R	Required field - Required for processing. DSHS will return records with missing, invalid, or uncorrectable values. Contractors must correct returned records and submit within 90 calendar days.
*	Applicable field - Information entered into these fields(30-33)is used to identify valid Patient Identification Codes (PIC) when a plan either does not submit a PIC or the submitted PIC is invalid.
O	Optional field -Contractors are encouraged to submit optional information
E	Field at the encounter level
L	Field at the line item level
X	Cobol Picture for character or alphanumeric field
9	Cobol Picture for numeric field
V99	Implied decimal point followed by 2 digits

#	FIELD NAME	LEVEL	ENCOUNTER TYPE				PHYSICAL RECORD LAYOUT		
			J,L, P	R	M	D	COBOL PICTURE	OCCURS	START POSITION
1	Encounter Type Indicator	E	R	R	R	R	X(1)	1	1
2	Encounter ID	E	R	R	R	R	9(9)	1	2
3	Line Item Number	L	R	R	R	R	9(2)	1	11
4	PIC	E	R	R	R	R	X(14)	1	13
5	Date of Birth	E	R	R	R	R	9(6)	1	27
6	Plan ID	E	R	R	R	R	9(7)	1	33
7	Billing Provider Medicaid Number	E	R Required only if the provider has a Medicaid provider ID	R	R	R	9(7)	1	40
8	Performing/Attending or Prescribing Provider Medicaid Number	E	R Required only if the provider has a Medicaid provider ID	R	R	R	9(7)	1	47
9	DRG	E		R			9(3)	1	54
10	Hospital Admission Date	E		R			9(6)	1	57
11	Patient Destination on Discharge	E		R			X(2)	1	63
12	Line Billed Charges	L		R	R		9(7)V99	1	65
13	Date of Service	L	R	R	R	R	9(6)	1	74
14	Hospital Discharge Date	E		R			9(6)	1	80

#	FIELD NAME	LEVEL	ENCOUNTER TYPE				PHYSICAL RECORD LAYOUT		
			J,L, P	R	M	D	COBOL PICTURE	OCCURS	START POSITION
15	Place of Service	E	R		R		X(1)	1	86
16 IP	Primary Procedure: Report ICD.9.CM procedures.	E		R			X(5)	1	87
16 Not IP	Primary Procedure: Applicable to 'M' encounters: If there is no Revenue Code in Field #21, then a CPT, HCPCS, or ICD.9.CM code is required. If there is a valid Revenue Code and no procedures to report, then hyphen-fill this field.	L	R		R		X(5)	1	87
17	Other ICD.9.CM Procedure Codes ('M' or 'R' encounters).	E		R	R		X(5)	5	92
18	Procedure Code Modifier	L	R		R		X(2)	1	117
19	Principal Diagnosis Code	L	R	R	R		X(7)	1	119
20	Other Diagnosis Codes	E		R	R		X(7)	8	126
21	Revenue Code Applicable to 'M' encounters: If Field #16 has CPT, HCPCS, or ICD.9.CM procedure code - 8-fill if no Revenue Code.	L		R	R		9(4)	1	182
22	National Drug Code (NDC)	L				R	X(11)	1	186
23	Units of Service	L	R	R	R	R	9(7)	1	197
24	EPSDT Referral Indicator	E	R (L)				X(2)	1	204
25	Plan Record ID (EPRI)	E	O	O	O	O	X(20)	1	206
26	Newborn Birth Weight	E		R	R		9(4)	1	226
27	Prescription Number	L				R	X(7)	1	230
28	Claim Status	E	R	R	R	R	X(1)	1	237
29	Line Status	L	R	R	R	R	X(1)	1	238
30	Patient's First Name	E	*	*	*	*	X(17)	1	239
31	Patient's Middle Initial	E	*	*	*	*	X(1)	1	256
32	Patient's Last Name	E	*	*	*	*	X(20)	1	257
33	Patient's SSN	E	*	*	*	*	X(9)	1	277
34	Subscriber's First Name	E	O	O	O	O	X18)	1	286
35	Subscriber's Last Name	E	O	O	O	O	X(20)	1	304
36	Subscriber's SSN	E	O	O	O	O	X(9)	1	324
37	Subscriber's Birth Date	E	O	O	O	O	9(6)	1	333
38	Alternate Billing Provider ID: Tax or NABP Identifier.	E	R/O	R/O	R/O	R/O	X(10)	1	339

#	FIELD NAME	LEVEL	ENCOUNTER TYPE				PHYSICAL RECORD LAYOUT		
			J,L, P	R	M	D	COBOL PICTURE	OCCURS	START POSITION
			Required only if the provider has no Medicaid provider number.						
39	Alternate Performing / Attending or Prescribing Provider ID: State License Number or DEA Identifier	E	R/O Required only if the provider has no Medicaid provider number.	R/O	R/O	R/O	X(10)	1	349
40	ED Processor Tax ID	E	O	O	O	O	X(10)	1	359
41	Hospital Patient Control Number (PCN)	E		R	O		X(20)	1	369
42	FILLER						X(47)	1	389
ERROR FLAG FORMAT (DSHS COMPLETES)									
43	Error Flag 1 Enc, Type						X(1)	1	436
44	Error Flag 2 Enc. ID						X(1)	1	437
45	Error Flag 3 Line Item						X(1)	1	438
46	Error Flag 4 PIC						X(1)	1	439
47	Error Flag 5 Date of Birth						X(1)	1	440
48	Error Flag 6 Plan #						X(1)	1	441
49	Err. Flg 7 Bill. Prov. Medicaid #						X(1)	1	442
50	Err. Flg 8 Perf. Prov Medicaid #						X(1)	1	443
51	Error Flag 9 DRG						X(1)	1	444
52	Err. Flag 10 Hosp. Admit Date						X(1)	1	445
53	Err. Flg 11 Disch. Destination						X(1)	1	446
54	Err. Flg 12 Line Billed Charge						X(1)	1	447
55	Error Flag 13 Date of Service						X(1)	1	448
56	Err. Flg 14 Hosp. Disch. Date						X(1)	1	449
57	Error Flag 15 Place of Service						X(1)	1	450
58	Error Flag 16 Principal Proc.						X(1)	1	451
59	Error Flag 17-1 to 17-5: Other ICD.9.CM Procedures						X(1)	5	452
60	Error Flag 18 Proc. Modifier						X(1)	1	457
61	Error Flag 19 Principal Diag.						X(1)	1	458
62	Error Flag 20-1 to 20-8 Other Diagnoses						X(1)	8	459
63	Error Flag 21 Revenue Code						X(1)	1	467
64	Err. Flg 22 National Drug Code						X(1)	1	468
65	Error Flag 23 Units of Service						X(1)	1	469
66	Err. Flg 24 EPSDT Refer. Ind.						X(1)	1	470
67	Filler hyphen-filled: Had been Err. Flg 25 Enc. Plan Rec. ID						X(1)	1	471
68	Err. Flg 26 Newborn Birth Wt.						X(1)	1	472

#	FIELD NAME	LEVEL	ENCOUNTER TYPE				PHYSICAL RECORD LAYOUT		
			J,L, P	R	M	D	COBOL PICTURE	OCCURS	START POSITION
69	Error Flag 27 Prescription No.						X(1)	1	473
70	Error Flag 28 Claim Status						X(1)	1	474
71	Error Flag 29 Line Status						X(1)	1	475
72	Err. Flg 30						X(1)	1	476
73	Err. Flg 31						X(1)	1	477
74	Err. Flg 32						X(1)	1	478
75	Error Flag 33						X(1)	1	479
76	Error Flag 38 Bill.Prov. Alt. ID						X(1)	1	480
77	Error Flag 39 Perf.Prov. Alt. #						X(1)	1	481
78	Error Flag 40						X(1)	1	482
79	Association Flag 41 Patient not eligible on date of service						X(1)	1	483
80	Assn. Flg 42 Perf.Prov Medi. # is not active on date of service						X(1)	1	484
81	Assn. Flg. 43 Invalid age for diagnosis						X(1)	1	485
82	Assn Flg 44 Invalid sex x diag.						X(1)	1	486
83	Assn Flg 45 Invalid age x proc.						X(1)	1	487
84	Assn Flg 46 Invalid sex x proc.						X(1)	1	488
85	Assn. Fl. 47 Invalid place x procedure						X(1)	1	489
86	PIC Change Flag						X(1)	1	490
87	PCN Error Flag						X(1)	1	491
88	Prescription Days Supply	L				R	9(3)	1	492
89	Err.Flg.Prescrip. Days Supply						X(1)	1	495
90	Alternate Bill-Provider ID Type	E	O	O	O	O	X(1)	1	496
91	Alternate Perf-Attend-Presc Provider ID Type	L	O	O	O	O	X(1)	1	497
92	Err. Flg Alt-Bill Prov ID Type						X(1)		498
93	Err. Flg Alt-Perf-Attend-Presc ID Type						X(1)	1	499
94	FILLER						X(1)	1	500

GENERAL DEFINITIONS AND DATA SOURCES

ENCOUNTER:

- One occurrence (e.g. an office visit); or
- A period of examination or treatment (e.g. inpatient hospital stay or long term care facility) by a medical practitioner or medical facility.

REPORT:

1) Any SERVICE or PROCEDURE listed in the following:

   - AMA Physicians' Current Procedural Terminology (CPT). Use the edition concurrent with reporting period.
   - Standard Edition International Classification of Diseases (ICD.9.CM)
   - State-specific Codes.
   - Health Care Financing Administration Comprehensive Procedure Coding System (HCPCS).
   - Dental ADA Procedure Codes.

   NOTE: All carrier and provider-specific ("in-house") codes must be converted to a corresponding code from one of the above listed sources.

2) Any VALID Provider Identifiers are allowed in the following list:

   - Medicaid Provider Numbers with active status (as per the monthly provider list);
   - Federal Tax Identification numbers used by the billing provider for reporting to the U.S. Internal Revenue Service;
   - State License numbers assigned by the Washington State Department of Health assigns to providers certified, registered or licensed in accordance with Title 18 RCW or Chapter 70.127 RCW;
   - DEA Identifier numbers assigned by the U.S. Drug Enforcement Administration;
   - NABP (National Association of Boards of Pharmacy) ID numbers. The NABP has been purchased by the National Council for Prescription Drug Programs (NCPDP) that now assigns this number. Refer to the NCPDP website for further information www.ncpdp.org/provider.asp.

FIELD ID	GENERAL FIELD DESCRIPTION
1	ENCOUNTER TYPE CODE Contractors are required to assign the services and codes to the associated encounter type specified on the attached Encounter Type Table. Enter a single character code to designate the type of encounter. Where EPSDT services are involved, encounters can have line item records with encounter type 'L' for EPSDT services and encounter type 'J' for non-EPSDT medical services. D - Drugs/Medications J - Medical Practitioner L - EPSDT M - Outpatient P - Medical Supplies/Equipment, Vision, Hearing, & Transportation R - Inpatient Hospital
2	ENCOUNTER IDENTIFICATION NUMBER A number assigned to each encounter and attached to each record in that encounter for the purpose of grouping records belonging to a single encounter. Number encounters sequentially in an encounter data file.
3	LINE ITEM NUMBER A number (e.g. 01, 02, 03 etc.) assigned sequentially to each instance/item separately reported in a single encounter.
4	PIC = PERSONAL IDENTIFICATION CODE Identifier assigned to each recipient approved for Medicaid. DSHS provides a list of Medicaid recipients enrolled with the plan to the Contractor on a monthly basis. The list includes each recipient's PIC. The PIC is to be reported in Field 4 in DATA format: o First 5 characters of last name (Blank-fill unused positions); o Initial character of first name; o Initial character of middle name (If no middle initial, a hyphen is shown); o Date of birth in YYMMDD format; o A tiebreaker code (assigned by DSHS at time of enrollment). For NEWBORNS use mother's PIC only until newborn has own PIC and it is no more than 90 days after date of birth or: o The family moves out of state; o The newborn is adopted, placed in foster care or dies before getting a PIC; or o The mother leaves the Contractor within 30 calendar days of the birth and the newborn never appears on the payment or enrollment listing for the Contractor.
5	DATE OF BIRTH Patient birth date formatted: MMDDYY. Use newborns birth date when using mother's PIC.
6	PLAN ID The Medicaid Provider Number assigned to the carrier designating the contract under which the member is enrolled (e.g. Healthy Options, Basic Health Plan Plus).

FIELD ID	GENERAL FIELD DESCRIPTION
7	BILLING PROVIDER ID - The Medicaid Provider Number assigned to the: o CLINIC or PROVIDER PRACTICE of the encounter's performing/attending provider. o CONTRACTOR, when it is the sole performing/attending provider's employer. o FACILITY reporting inpatient and outpatient services. (Encounter Types R and M). o PHARMACY for the reporting of Drug encounters (Encounter Type D). o HOME HEALTH/HOSPICE AGENCY when independently operated (Encounter type M).
8	PERFORMING/ATTENDING OR PRESCRIBING PROVIDER ID A Medicaid Provider number assigned to: o The provider who renders the service for Medical Practitioner (Encounter Type J), EPSDT (Encounter Type L), Inpatient Hospital (Encounter Type R) and Outpatient Hospital (Encounter Type M). o For prescribed services, prescriptions, and supplies use the Medicaid Provider Number of the 'prescribing' practitioner who writes the prescription. This applies to writers of orders for drug prescriptions (Pharmacy Encounter Type D), Medical Supplies or equipment (Encounter Type P), or Laboratory, Radiology, and other diagnostic services (within Encounter Type J). For Inpatient claims this field should identify the Attending Provider as described in instructions for UB-92 FL-82.
9	DRG CODE INPATIENT HOSPITAL (ENCOUNTER TYPE R) ONLY Diagnosis Related Group (DRG) Codes developed using All Patient DRG (AP-DRG) Grouper Version 14.1 from 3M/HIS. If this number is not available from the hospital reporting the encounter, the carrier will have to determine the appropriate DRG.
10	HOSPITAL ADMISSION DATE Format: MMDDYY Source: UB-92: FL-17, "Admission Date"
11	PATIENT DESTINATION ON DISCHARGE Applies only to Inpatient Hospital (Encounter Type 'R'). Location to where a patient was discharged. Code Destination at discharge 01 Home discharge 02 Discharge/Transfer General Hospital 03 Discharge/Transfer SNF 04 Discharge/Transfer ICF 05 Discharge/Transfer INST 06 Discharge/Transfer Home 07 Left against medical advice 08 Home discharge with IV Therapy 20 Death Source: UB-92: FL-22, "Patient Status"

FIELD ID	GENERAL FIELD DESCRIPTION
12	LINE BILLED CHARGES Applies to hospital (M and R) encounters only. Enter the line-billed charges for each Revenue Code reported on an inpatient hospital encounter and the line-billed charges for each Revenue Code and CPT or HCPCS Code reported on an outpatient hospital encounter. Source: UB-92: FL-47, Line charges associated with the service codes reported in the rows of the "Total Charges" column.
13	DATE OF SERVICE Format: MMDDYY Source: Hospital Inpatient upon discharge (Encounter Type R) & Outpatient (Encounter Type M) - Source: UB 92: FL-6, "Through" date; Pharmacy (Encounter Type D) -Source: Form 525-106: FL-9, "Fill Date"; Medical Practitioner, EPSDT, & Medical Equip, etc. (Encounter types J, L, & P) - Source: HCFA 1500 FL-24.
14	HOSPITAL DISCHARGE DATE Format: MMDDYY Source: UB 92: FL-6, "Through."
15	PLACE OF SERVICE CODES Note: These codes are different from Medicare Place-of-Service codes. Code — Place of Service 1 — Hospital, Inpatient 2 — Hospital, Outpatient 3 — Office or ambulatory surgery center 4 — Client's residence 5 — Emergency room 6 — Congregate care facility 8 — Skilled nursing facility 9 — Other
16	PRIMARY PROCEDURE CODE Includes Primary ICD.9.CM Procedure Code if applicable: o Medical Practitioner (Encounter Type J), EPSDT (Encounter Type L) and Medical Supplies (Encounter Type P) CPT, HCPCS procedure codes. Source: HCFA-1500: FL-24D, "CPT/HCPCS". o Dental ADA Procedure Codes. Source: Form 525-108: FL-15G, "Procedure Number" o Hospital, Inpatient (Encounter Type R) ICD.9.CM Procedure Codes. Source: UB-92: FL-80, "Principal Procedure Code" o Hospital, Outpatient (Encounter Type M) CPT or HCPCS Procedure Codes and/or ICD.9.CM Procedure Codes. Source: UB-92: FL-44, "HCPCS/Rates" FL-80, "Principal Procedure Code". (Hyphen-fill FL-16 if reporting a Revenue Code and there is no CPT or HCPCS code to report. o If Revenue Code F21 is reported on an Outpatient Hospital encounter record (Encounter Type M) DO NOT report a CPT or HCPCS or ICD.9.CM procedure in FL 16 for the same record. (8-fill FL 21 if reporting a procedure code and not reporting Revenue Code.)
17	OTHER ICD.9.CM PROCEDURE CODES (up to 5) Hospital, Inpatient (Encounter Type R) and Outpatient (Encounter Type M) Source: UB-92: FL-81A-E, "Other Procedure Codes". These should be repeated on each line of an inpatient encounter.
18	PROCEDURE CODE MODIFIER Applicable to all encounters, excluding Inpatient Hospital.

FIELD ID	GENERAL FIELD DESCRIPTION
	Medical Practitioner (Encounter Type J), EPSDT (Encounter Type L), Outpatient Hospital (Encounter Type M) when using CPT or HCPCS procedure codes, and Medical Supplies (Encounter Type P). Source: HCFA-1500: FL-24D, "Modifier". Dental Source: Form 525-108: FL-15H, "Mod".
19	PRINCIPAL DIAGNOSIS CODE o Only ICD.9.CM diagnosis codes are allowed. o Coding must be explicit using the maximum number of digits appropriate AND including the decimal point where applicable. Medical Practitioner (Encounter Type J), EPSDT (Encounter Type L) and Medical Supplies (Encounter Type P) Source: HCFA-1500: FL-24E, "Diagnosis Code"; Dental: Source: 525-108: FL-5, "Dental Diagnosis Code"; Hospital, Inpatient (Encounter Type R) and Outpatient (Encounter Type M) Source: UB- 92: FL-67, "Principal Diagnosis Code".
20	OTHER DIAGNOSIS CODES (up to 8) Applicable to hospital encounters only Hospital, Inpatient (Encounter Type R) and Outpatient (Encounter Type M) Source: UB- 92: FL-68-75, "Other Diagnosis Codes". Hyphen-fill unused diagnosis fields (See example-Generic Field Specifications).
21	REVENUE CODE Applicable to hospital encounters only. For Outpatient: Either a Revenue Code or a Procedure Code is required for each line item, but NOT BOTH. For Hospital Inpatient, Revenue Code is required. Hospital Inpatient (Encounter Type R) and Outpatient (Encounter Type M) Source: UB-92: FL-42. (8-fill when using a Procedure Code in FL 16.)
22	NATIONAL DRUG CODE (NDC) Applicable to Pharmacy (Encounter Type D) only Enter eleven-digit NDC number without hyphens/spaces. Source: Form 525-106: Field "National Drug Code". Include NDCs for over-the-counter medications. Use the Food and Drug Administration's (FDA's) website to verify federally covered Medicaid NDCs: http://www.fda.gov/cder/.

FIELD ID	GENERAL FIELD DESCRIPTION
23	UNITS OF SERVICE o A quantitative measure of services provided. o Hospital Inpatient (Encounter Type R) Revenue Codes 100 - 210 Accommodations: number of days. Source: UB-92: FL-46, "Units of Service" o Hospital Outpatient (M type) Revenue Code 45X Emergency Room: number of visits. Source: UB-92: FL-46, "Units of Service" o Pharmacy (Encounter Type D) Source: Form 525-106: Field "Quantity - Filled" o Medical Practitioner (J type), EPSDT (L type) and Medical Supplies (Encounter Type P). Source: HCFA-1500: FL-24G, "Days or Units" o Dental - Source: Form 525-108: FL-15F, "Units"
24	EPSDT REFERRAL INDICATOR [EPSDT = Early and Periodic Screening Diagnosis and Treatment] Applicable to EPSDT encounters only (Encounter Type L or Type J when an encounter involves both L and J types of services). A two-digit code that indicates that a patient was or was not referred for treatment as the result of the EPSDT visit: YR - yes, referred NR - no, not referred If a plan cannot obtain the referral indicator, then leave this field blank. Although this will result in an error during the MAA edit, the plan is required to report the encounter. Errors due to blank fills will be tracked separately. Source: HCFA-1500: FL-24D: "Modifier".
25	PLAN RECORD ID CODE (EPRI) - A plan-assigned code that uniquely identifies the encounter in the submitted encounter data and in the plan's internal database. The EPRI is Optional for the Year 2003.
26	NEWBORN BIRTH WEIGHT Hospital encounters for newborns must include the Birth Weight in grams. Hospital, Inpatient (R type) and Outpatient (M type) Source: UB-92: is given in the "Value Amount column of FL-39-41 a-d where the Value Code ="80" (in grams).
27	PRESCRIPTION NUMBER Applicable to Pharmacy (D type) encounters only. A seven-character code assigned in sequence to regular prescriptions filled by the pharmacy. Contractors may use the original prescription number for refills or assign a new number. Source: Form 525-106: Field "Prescription Number".
28	CLAIM STATUS Indicates whether all services of the submitted encounter were denied or one or more services were paid/accepted. N = Paid or Accepted (e.g. for services provided on a capitation basis). If an inpatient claim is paid on a DRG basis, then use Claim Status N. P = Denied (Includes only finalized claims where disposition is a denial).

FIELD ID	GENERAL FIELD DESCRIPTION
29	LINE STATUS Indicates whether or not payment for an individual service was denied or paid/accepted. For inpatient encounters that are paid or denied based on DRG code, code all lines of the encounter as "N" = paid/accepted, unless claim was denied ("P" = Denied). N = Paid/Accepted (e.g. for services provided on a capitation basis). P = Denied
30-33	PATIENT FIRST NAME, MIDDLE INITIAL, LAST NAME and SSN. If there is no middle initial or it is unknown, insert a "-" in Field 31.
34-37	SUBSCRIBER FIRST NAME, LAST NAME, SSN and BIRTH DATE (optional). The Subscriber is the head of household in which the patient resides and/or a guardian (for patients who are dependents). Patient and Subscriber can be the same. Information may be used for PIC match.
38	ALTERNATE BILLING PROVIDER ID is required if the billing provider does not have a valid Medicaid Provider Number. Medicaid Provider Numbers may be used in combination with any of the following Alternate Billing provider Identifiers: Federal Tax Identifier, or NABP Identifier.
39	ALTERNATE PERFORMING/ATTENDING OR PRESCRIBING PROVIDER ID is required if the performing/attending or prescribing provider does not have a valid Medicaid Provider Number. Medicaid Provider Numbers may be used in combination with any of the following Alternate Performing/Attending or Prescribing provider Identifiers: State License Number, or DEA Identifier. When service is given out-of-state, report the license number issued by the associated state. See Field #8 for determining when to report the performing/attending or prescribing provider.
40	ENCOUNTER DATA PROCESSOR TAX ID Optional field to assist Contractor in tracking encounter records to their processors.
41	HOSPTIAL PATIENT CONTROL NUMBER (PCN) Applicable to hospital claims (Encounter Type R - required and M - optional). Patient's unique alphanumeric number assigned by the provider to facilitate retrieval of individual case record. CHARS reporting requires that hospitals make the PCN unique. An encounter record PCN must match the PCN reported in the associated claims reported to CHARS. For services given out-of-state, the PCN number assigned by the hospital should be reported. For hospitals that use patient-based PCNs on their UB92 claims, Contractors should replicate the numbering scheme used by those hospitals to make their PCN unique and transaction based for their CHARS submissions. For example, if a hospital makes a patient-based PCN unique by adding the admit date, the Contractor can do the same for that encounter record. Source: UB92 Manual Form Locator 3 and the CHARS Procedure Manual for Submitting Discharge Data, UB92 Data Elements, page 11.
42	FILLER

FIELD ID	GENERAL FIELD DESCRIPTION
43-78	ERROR FLAGS - Position #'s 436-482 Codes: '1' = field value did not pass edits ' ' (blank) = field value did pass edits '-' = no edit required Codes unique to specific error flag fields: Error Flag Field 21 - Revenue Codes: o Code '-' = no edit required. o Code '1' = required revenue code is not valid or is blank. o Code ' ' (blank) = required revenue code is valid. o Code 'M' = required revenue code is modified. o Code 'C' = modified value is valid. Error Flag Field 12 - Lined Billed Charges: o Code 'Z' - field 12 = zeros o Code 'U - field 12 = all 9's (i.e. 9999999.99) o Code 'I' - field 12 = all 8's (i.e. 8888888.88) o Code 'N' - field 12 = 099999999 (i.e. 0999999.99) o Code 'E' - field 12 = 088888888 (i.e. 0888888.88) o Code 'G' - field 12 = any other non-numeric or low values
	The following edits are used to validate data in the specified fields (Position #s 483-489)
79	ASSOCIATION FLAG 41 Recipient not eligible for date of service
80	ASSOCIATION FLAG 42 Performing provider not active for date of service
81	ASSOCIATION FLAG 43 Invalid recipient age for diagnosis
82	ASSOCIATION FLAG 44 Invalid recipient sex for diagnosis
83	ASSOCIATION FLAG 45 Invalid recipient age for procedure
84	ASSOCIATION FLAG 46 Invalid recipient sex for procedure
85	ASSOCIATION FLAG 47 Invalid place of service for procedure

86	PIC-CHANGE-FLAG [PIC = Patient Identification Code] Completed by DSHS. When the PIC submitted in Field 4 is invalid and a valid PIC is found by DSHS by any of the following:
	o Name (Fields 31, 32 & 33) and Date of Birth (Field 5);
	o Name and Social Security Number (Field 34); or
	o Social Security Number and Date of Birth;
	
	The matched PIC will replace the invalid PIC in Field 4 for use in all subsequent processing of the encounter record. One of the following codes will appear in Field 86:
	o C = PIC corrected;
	o V = original (submitted) PIC is valid;
	o I = invalid PIC submitted and no valid PIC identified through match process.

87	PCN ERROR FLAG (For explanation codes see for Field ID numbers 43-78 above.)
88	PRESCRIPTION DAYS SUPPLY: Number of days prescription is to cover. Source: Pharmacy Form 525-106: Field "Est. Days' Supply".
89	ERROR FLAG PRESCRIPTION DAYS SUPPLY: Same codes as for fields 43-78.

FIELD ID	GENERAL FIELD DESCRIPTION
90	ALTERNATE BILLING PROVIDER ID: required if no valid Medicaid Provider Number is reported - Hyphen-fill if no Alternate Identifier is reported and a Medicaid Provider Number is reported: o United States Federal Tax Identifier. Leave Field 90 blank if alternate Tax Identifier is reported. No error will be generated. o N = National Association of Boards of Pharmacy Identifier, recently purchased by the National Council for Prescription Drug Programs (NCPDP) and also known as the NCPDP Identifier.
91	ALTERNATE PERFORMING/ATTENDING OR PRESCRIBING PROVIDER ID: REQUIRED IF NO VALID MEDICAID ID IS REPORTED Hyphen-fill if no Alternate Identifier is reported and a Medicaid Provider Number is reported: o Washington State Professional License Number. If the service is given out-of-state then the performing/attending or prescribing license number refers to the license number issued by the state in which the provider is licensed. Leave Field 91 blank if an alternate State License Identifier is reported. No error will be generated. o D = U.S. Drug Enforcement Agency issued DEA Identifier.
92	ERROR FLAG ALT-BILLING PROVIDER ID (FIELD 90)
93	ERROR FLAG ALTERNATE PERF/ATTEND OR PRESCR. PROVIDER (FIELD 91)

ENCOUNTER TYPE TABLE

Contractors are required to assign at least the services and codes specified below to the associated encounter types. Consult the 2003 HO/SCHIP contract for the Schedule of Benefits and the MAA Billing Instructions for further information on code and service encounter type designations (MAA Billing Instructions take precedence over the listing below).

E-TYPE CODE	DESCRIPTION OF ENCOUNTER TYPE	TYPES OF SERVICES FOR A COMPLETE LISTING SEE 2003 CONTRACT SCHEDULE OF BENEFITS	TYPICAL CPT-4 AND HCPCS CODES SEE MAA BILLING INSTRUCTIONS FOR COMPLETE LISTING OF CODES ASSOCIATED WITH COVERED SERVICE
D	DRUGS & MEDICATIONS Prescriptions ordered by the performing/attending or prescribing physician. Includes dispensing fee.	Includes only drugs and medications dispensed by a pharmacy. Does not include those provided during a J, M, or R encounter.	N/A
J	Medical Practitioner Services Professional charges only or the combined professional and technical charges for the following medical services provided in inpatient, outpatient, and office settings.	Surgery, including pre-and post-surgical encounters with the surgeon and assistant surgeon. Includes oral surgery services	10040-36410, 36420-55899, 56300-58301, 58340-58960, 58999, 59525, 60000-69020, 69100-69979, 69990, 92980-92998, 93501-93536, 93561-93572, A6020-A6406, G0051-G0053
		Anesthesia * MAA FFS: 00100-01999 are billed with surgery procedure + modifier	00100-01999, 99100-99142 or 10040-36410, 36420-55899, 56300-58301, 58340-58960, 58999, 59525, 60000-69020, 69100-69979, 69990, 92980-92998, 93501-93536, 93561-93572 with anesthesia modifier
		Maternity	59400-59430, 59610-59614, 59899, 59510-59515, 59618-59622, 59899, 59000-59350, 59812-59871 (excluding 59840, 59841, 59850 through 59852 and 59855 through 59857)

E-TYPE CODE	DESCRIPTION OF ENCOUNTER TYPE	TYPES OF SERVICES FOR A COMPLETE LISTING SEE 2003 CONTRACT SCHEDULE OF BENEFITS	TYPICAL CPT-4 AND HCPCS CODES SEE MAA BILLING INSTRUCTIONS FOR COMPLETE LISTING OF CODES ASSOCIATED WITH COVERED SERVICE
J	MEDICAL PRACTITIONER SERVICES (continued) "J" and "L" encounter types may occur on different records for the same encounter.	Visits, consults and urgent care	99175-99195, 99221-99239, 99356-99357, 99431, 99433-99440; 99201-99215, 99241-99275, 99201-99215, 99321-99355, 99361-99380, 99385 (for persons age 21-39), 99386-99387, 99395 (for persons age 21-39), 99499
		Critical care	99291-99316, 99217-99220, 99281-99288
		Physical Medicine & Rehabilitation	97001-97799, 98925-98929; H5300, Q0082, Q0086, Q0103-Q0110
		Cardiovascular	92950-92979, 93000-93350, 93539-93556, 93600-93799; G0004-G0007, G0015-G0016, M0300-M0302
		Immunizations	90471-90472, 90476-90749; G0008-G0010, J1670
		Mental Health	90816-90829
		Newborn care	99431-99436,99440
		Vision & Hearing/ Speech Exams	92002-92015, 92310, 92314 92506-92510, 92551-92599; V5008-V5010, V5362-V5364
		Physical Exams	99386, 99387, 99396, 99397, 99401-99429
		Pathology	80049-89399; G0058-G0060, P2028-P9615, Q0068, Q0091, Q0111-Q0115
		Radiology	70010-79999; A4647-A4649, A9500-A9600, G0030-G0050, Q0035, Q0092, R0070-R0076
		Therapeutic injections	90281-90399, 90780-90799, J0120-J1650, J1690-J7310, Q0081, Q9920-Q9940
		Allergy testing & Immunotherapy	95004-95078, 95115-95199

E-TYPE CODE	DESCRIPTION OF ENCOUNTER TYPE	TYPES OF SERVICES FOR A COMPLETE LISTING SEE 2003 CONTRACT SCHEDULE OF BENEFITS	TYPICAL CPT-4 AND HCPCS CODES SEE MAA BILLING INSTRUCTIONS FOR COMPLETE LISTING OF CODES ASSOCIATED WITH COVERED SERVICE
J	MEDICAL PRACTITIONER SERVICES (continued)	Miscellaneous medical services such as Venipuncture, Biofeedback, Dialysis, Gastroenterology, Ophthalmology, Otorhinolaryngology, Vestibular Function Tests, Non-Invasive Vascular Diagnostic Studies, Pulmonology, Neurology, Central Nervous System Tests, Chemotherapy, Dermatology, or Podiatry.	36415, 90901, 90911, 90918-90999, A4650-A4927, 91000-91299, 92018-92287 92311-92313 92315-92317 92330, 92335 92352-92358 92371 92393-92499, 92502-92504 92511-92526, 92531-92548, 93875-93990, 94010-94799, 95805-95999, 95805-95999, 96400-96549, J8530-J9999, 96900-96999, 99000-99070 99199, 99360, G0001-G0002 G0025-G0027 G0062-G0063 Q0083-Q0085 M0075-M0076 M0010 M0101
L	EPSDT All covered services for children age 0 - 20 "J" and "L" encounter types may occur on different records for the same encounter.	Well Baby/Well Child Exams	99381-99384, 99385 (for ages 18-20), 99391-99394, and 99395 (for ages 18-20)
		Immunizations	90471-90472, 90476-90749; G0008-G0010, J1670
		Interperiodic well child visit	0203M, 0252M
		Chiropractic: Visits, manipulations and radiology services provided in the chiropractor's office.	98940-98943, A2000
M	OUTPATIENT facility charges for the technical components and services performed by full-time staff of a hospital outpatient, freestanding facility, ambulatory surgical center, FQHC or RHC, kidney dialysis center, mobile radiology unit, or birthing center for the following types of medical services. Does not include professional charges that are billed separately		Emergency & Urgent Care; Maternity: delivery, non-delivery (miscarriages, therapeutic abortions, ultrasound, amniocentesis), & well newborn care; Outpatient Surgery including oral surgery, Anesthesia, Radiology & Pathology; Pharmacy and Blood; Cardiovascular tests such as EKG and stress tests; Physical therapy, occupational therapy, and speech therapy; Home health; Hospice; Chemotherapy; Diagnostic services

E-TYPE CODE	DESCRIPTION OF ENCOUNTER TYPE	TYPES OF SERVICES FOR A COMPLETE LISTING SEE 2003 CONTRACT SCHEDULE OF BENEFITS	TYPICAL CPT-4 AND HCPCS CODES SEE MAA BILLING INSTRUCTIONS FOR COMPLETE LISTING OF CODES ASSOCIATED WITH COVERED SERVICE
P	MEDICAL SUPPLIES, APPLIANCES, EQUIPMENT, VISION, HEARING AIDS, AND TRANSPORTATION: Includes only those dispensed by a medical supplier. Does not include those provided during a J, M, or R encounter.	Braces (orthotics), canes, crutches, glucoscan, glucometer, intermittent positive pressure machines, rib belt for treatment of an accident or illness, walker, wheel chairs, etc; artificial parts that replace a missing body part or improve a body function (i.e., artificial limb, heart valve, medically necessary reconstruction); glasses or contacts; and ambulance.	A4206-A4646, A5051-A5149, A5500-A5507, B4034-B9999, E0100-E1830, K0001-K0116, K0137-K0439, K0452, L0100-L4398, V2600-V2615, V5336 K0440-K0451, L5000-L8690, V2623-V2632; 92325-92326, 92340-92342, 92370, 92390-92392; V2020-V2599, V2700-V2799; A0021-A0999, A6020-A6406
R	INPATIENT HOSPITAL: Inpatient room and board and ancillary services in short-term community hospitals. Ancillary services include use of surgical and intensive care facilities, inpatient nursing care, pathology and radiology procedures, drugs and supplies. Facility charges for technical components and services performed by full-time staff of a hospital on an inpatient basis. Does not include professional charges unless performed by full-time staff of the facility and not billed separately.		Medical & Surgical Confinement Surgery, Emergency & Urgent Care; Skilled Nursing Facility; Maternity: delivery, complications of pregnancy, non-delivery (includes miscarriages & therapeutic abortion), & well newborn care; Surgery, Anesthesia, Radiology & Pathology; Pharmacy and Blood; Chemotherapy; Diagnostic services

EXHIBIT C-2(a)
2003 IPND REPORTING REQUIREMENTS
BASIC HEALTH PLAN (BHP), HEALTHY OPTIONS (HO),
PUBLIC EMPLOYEES BENEFIT BOARD (PEBB),
AND CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)

Note: Validate the field type and maximum size, values bolded, and whether the field is required or not, for each Provider Type.

	FIELD NAME	FIELD TYPE	SIZE	DEFINITION	PROVIDER TYPES (SEE FOOTNOTES)			EDIT
					PRAC	HOSP	PHA	
Carrier Area	Program Type	Numeric	1	The program supported by the Practitioner, hospital or pharmacy at this location. HO = 1, BHP = 2, PEBB = 4, CHIP= 8. A separate record must be submitted for each program type.	X	X	X	TR
	InternalProviderID	Text	15	The internal identification number by which the Carrier refers to the Health Care Provider. Required for PEBB PCPs, using ProviderClinic code (used for enrollment purposes).	A	A	A	ERR
	Credential Date	Date	10	The date the Carrier last credentialed the Practitioner. Must be in correct format: MM/DD/YYYY, a valid date, and not a date in the future.	A			ERR
	Obstetric	Yes/No	1	Does the Practitioner offer Obstetric services, including birthing?	X			
	PSB	Text	1	A single upper-case character indicating: P = Primary Care Provider, S = Specialist, B = Both.	X			TR
	AcceptNewPatients	Yes/No	1	Does the Practitioner currently accept new enrollees?	X			
	Limits	Text	50	The practice limitations the Practitioner places on his/her services (e.g., age 0-19, 2 days a week). *Required only if the carrier is aware of practice limitations.	*X			
	AfterHoursPhone	Text	23	Telephone number of the business (not a specific Practitioner) for after normal business hours. Format: (nnn) nnn-nnnn ext. nnnnn. (Telephone extensions are optional)	X	A	A	ERR
	SpecialtyPrimary	Text	50	The full name or approved abbreviation of the specialty offered by the Practitioner under the current contract. (see tblSpecialtyType for approved specialties and their abbreviations)	X			TR
	SpecialtySecondary	Text	50	The full name or approved abbreviation of the specialty offered by the Practitioner under the current contract. Can be multiple if active. (see tblSpecialtyType for approved specialties and their abbreviations)	A			

X = Required Field
*X = Required only if carrier is aware of this information
A = Required if applicable
Blank = Optional

TR = Total Reject (don't work record)
ERR = Error (blank the field in error but still work the record)

Note: Validate the field type and maximum size, values bolded, and whether the field is required or not, for each Provider Type.

	FIELD NAME	FIELD TYPE	SIZE	DEFINITION	PROVIDER TYPES (SEE FOOTNOTES) PRACT	HOSP	PHAR	EDIT
	Start	Date	10	The effective date the Practitioner, Hospital or Pharmacy entered/will enter into a contract with the carrier to administer health care for each place of business for each program: HO, BHP or PEBB. Must be in correct format: MM/DD/YYYY and a valid date.	X	X	X	TR
	End	Date	10	The date the Practitioner, Hospital or Pharmacy ended/will end their contract to administer health care for each place of business for each program: HO, BHP or PEBB. If there is not a known contract end date, field can be left blank. Must be in correct format: MM/DD/YYYY and a valid date	*X	*X	*X	TR
	RestrictedMSO	Text	35	If the provider is a member of a group that delivers services through a sub-capitated (risk-based) arrangement and does not permit enrollees to use providers outside of that group for routine primary and referral care, list the name of that provider group. *If the provider is not a member of such a group, leave blank.	*X			
	Language	Text	30	Language(s), other than English, in which the Practitioner is fluent. This does not include all languages that may be available at the Health Care Provider's place of business. (see tblLanguage for approved abbreviations).	*X			
	Capacity	Numeric	4	The maximum number of clients the Primary Care Provider can manage under the current contract for each program, listed separately. (Applies to provider Type 1 records only)				
Provider Area	LastName	Text	25	The last name, family name or surname of the Practitioner and any suffix that applies (i.e. Sr., Jr., etc.)	X			TR
	FirstName	Text	15	The first or given name of the Practitioner.	X			TR
	MiddleName	Text	15	The middle name(s) or initial(s) of the Practitioner.	A			
	ProfDegree	Text	10	The professional title of the Practitioner. This title may refer to a graduate title received from a college or university, or may refer to the title on the professional license (e.g. MD, DO, ARNP, PA, LM, CNM). Can be multiple if active.	X			TR
	DOB	Date	10	The date of birth of the Practitioner, for internal data management purposes, not public distribution. Must be in correct format: MM/DD/YYYY, a valid date, not be a date in the future, and be a minimum age of 16 years old.	X			ERR
	Gender	Text	1	The gender of the Practitioner (M or F).	A			ERR
	PractitionersNPI	Text	10	The Practitioner's National Provider Identification number. As the NPI numbers are assigned, the carrier must report the identification number. Not currently required.	A			

X = Required Field
*X = Required only if carrier is aware of this information
A = Required if applicable
Blank = Optional

TR = Total Reject (don't work record)
ERR = Error (blank the field in error but still work the record)

Note: Validate the field type and maximum size, values bolded, and whether the field is required or not, for each Provider Type.

	FIELD NAME	FIELD TYPE	SIZE	DEFINITION	PROVIDER TYPES (SEE FOOTNOTES) PRACT	HOSP	PHAR	EDIT
	LicensePrimary	Text	10	State-issued professional license number. Submitted in complete format and match the following patterns. For WAshington = [A-Z][A-Z]######## (ie MD12345678) For ORegon MD's: [A-Z][A-Z]#### (ieMD1234) For Oregon RN's: ####### (ie 1234567) For IDaho MD's: M-#### (ie M-1234) For IDaho PA's: PA-### (ie RPA-123) For IDaho RN's: ##### (ie N-12345)	X			TR
	LicensingStatePrimary	Text	2	The two-character upper case Postal Service abbreviation TR of the state issuing the professional license.	X			TR
	LicenseSecondary	Text	10	State-issued professional license number. Submitted in complete format and match the following patterns. For Washington = [A-Z][A-Z]######## (ie MD12345678) For Oregon MD's: [A-Z][A-Z]#### (ieMD1234) For Oregon RN's: ####### (ie 1234567) For IDaho MD's: M-#### (ie M-1234) For IDaho PA's: PA-### (ie RPA-123) For IDaho RN's: N-##### (ie N-12345)	A			ERR
	LicensingStateSecondary	Text	2	The two-character upper case Postal Service abbreviation of the state issuing the professional license.	A			ERR
Business Area	ProviderType	Numeric	1	Defines the type of provider services offered by the business: 1 = Practitioner, 2 = Hospital, 3 = Pharmacy.	X	X	X	TR
	BusinessName	Text	65	Name of Clinic, Office, Hospital or Pharmacy, as the public knows it. If a practitioner is located at more than one place of business, a separate record must be submitted for each address. The Business Name may be the Practitioner's name.	X	X	X	TR
	StreetAddress1	Text	36	The address of the physical location of the Clinic, Office, Hospital or Pharmacy. May not contain Post Office Box numbers or separate billing address. If a practitioner is located at more than one place of business, a separate record must be submitted for each address. No suite #s permitted, Use USPS Listing	X	X	X	TR
	StreetAddress2	Text	36	Overflow address line only if required. Not a different address location. No suite #s permitted.	A	A	A	
	City	Text	25	The full name of the city in which the business is physically located.	X	X	X	TR
	State	Text	2	The two-character upper-case Postal Service abbreviation of the state in which the Clinic, Office, Hospital or Pharmacy is physically located.	X	X	X	TR
	ZIP	Text	10	The postal ZIP code in which the Clinic, Office, Hospital or Pharmacy is located.	X	X	X	TR

X = Required Field
*X = Required only if carrier is aware of this information
A = Required if applicable
Blank = Optional

TR = Total Reject (don't work record)
ERR = Error (blank the field in error but still work the record)

Note: Validate the field type and maximum size, values bolded, and whether the field is required or not, for each Provider Type.

FIELD NAME	FIELD TYPE	SIZE	DEFINITION	PROVIDER TYPES (SEE FOOTNOTES) PRACT	HOSP	PHAR	EDIT
County	Text	15	The name of the County in which the Clinic, Office, Hospital or Pharmacy is physically located. Spelled out in full.	X	X	X	TR
Day Phone	Text	23	The telephone number of the business (not a specific Practitioner.) available during normal business hours to make an appointment. Format: (nnn) nnn-nnnn ext. nnnnn. (Telephone extensions are optional)	X	X	X	TR
BusinessNPI	Text	10	The National Provider Identification number given to the Clinic, Office, Hospital or Pharmacy. As the NPI numbers are assigned, the carrier must report the identification number. Not currently required.	A	A	A	
NAPB	Text	10	The Pharmacy Board identification number, to use as a unique identifier for pharmacies.			X	ERR
Comments	Text	255	Comments to IPND Coordinator regarding record.				
Website	Text	1	Is this record available to publish on the IPND Web Provider Directory Values of Y or N Defaults to Y				
Billing Address	Text	1	Is this record a billing address only? Values of Y or N Defaults to N				

X = Required Field
*X = Required only if carrier is aware of this information
A = Required if applicable
Blank = Optional

TR = Total Reject (don't work record)
ERR = Error (blank the field in error but still work the record)

EXHIBIT C-2 (b)
IPND ESCALATION PROCEDURE

The State of Washington has a contract with GeoAccess for provider network data management for Basic Health (BH), Healthy Options (HO), Children's Health Insurance Program (CHIP), and Public Employees Benefits Board (PEBB) programs. The following are guidelines in the event a carrier does not submit their monthly provider network report by the designated due date, for loading in the Integrated Provider Network Database (IPND). Late submissions are equal to non-submission for the month. Late submissions may be used as the next month's submission if another submission is not received before the deadline.

Late or No Submission	ESCALATION PROCEDURES
First Month	o GeoAccess will follow up with the carrier contact. o GeoAccess will notify the IPND Coordinator. o The IPND Coordinator will contact the carrier(s) via telephone and follow up in writing to determine and resolve reasons for late or non-submittal. IPND Coordinator will work with the plan to ensure timely future submission and update routines. o If no new submission is received by the due date the prior month's data will be re-entered in IPND.
Second Month	o GeoAccess will follow up with the carrier contact. o GeoAccess will notify the IPND Coordinator. o The plan will receive a "warning letter" from MAA/HCA. o Prior month's data will be re-entered in IPND.
Third Month	o No data for the carrier(s) will be displayed in the database until the next monthly submission is received. o Notification of the removal of carrier data will be sent to the HCA/MAA User Interface customers. o HCA/MAA will send written notice to the carrier(s) to inform them of their omission from the database and steps necessary to update IPND for their plan.

2003 HO SCHIP Contract
Exhibit D

Premiums, Service Areas and Capacity
Exhibit D-1, Capacity
Contractor: MHC
Effective: January 1, 2003

REGION	SERVICE AREA	CAPACITY
1	Island	5,000
1	San Juan	150
1	Skagit	9,000
1	Whatcom	7,000
2	Snohomish	500
3	King	61,000
3	Pierce	55,000
4	Clallam	4,000
4	Jefferson*	0*
4	Kitsap	9,000
5	Grays Harbor	7,000
5	Lewis	8,400
5	Mason	800
5	Pacific	1,000
5	Thurston	4,000
6	Clark*	0*
6	Cowlitz	6,400
6	Skamania*	0*
6	Wahkiakum*	0*
7	Adams	1,250
7	Chelan	10,000
7	Douglas	4,000
7	Grant	9,900
7	Okanogan	7,450
8	Kittitas*	0*
8	Klickitat*	0*
8	Yakima	4,000
9	Ferry*	0*
9	Lincoln	1,000
9	Pend Orielle	1,600
9	Stevens*	0*
10	Spokane	30,000
11	Asotin*	0*
11	Garfield	120
11	Whitman	2,300
12	Benton	9,000
12	Columbia	450
12	Franklin	8,500
12	Walla Walla	6,000

*NOTE: Shaded areas are those not currently served.

2003 HO SCHIP Contract
Exhibit D

Premiums, Service Areas and Capacity
Exhibit D-2, Adjustment Factors
Contractor: MHC
Effective: January 1, 2003

REGION	SERVICE AREA	GEO ADJ FACTOR	HO RISK ADJ FACTOR	
			1st Qtr	2nd - 4th Qtr
1	Island	1.005	0.974	
1	Skagit	1.005	0.974	
1	San Juan	1.005	0.974	
1	Whatcom	1.005	0.974	
2	Snohomish	1.053	0.977	
3	King	0.998	0.994	
3	Pierce	0.998	0.994	
4	Clallam	1.011	0.949	
4	Jefferson*	1.011*	0.949*	
4	Kitsap	1.011	0.949	
5	Grays Harbor	1.028	1.002	
5	Lewis	1.028	1.002	
5	Mason	1.028	1.002	
5	Pacific*	1.028*	1.002*	
5	Thurston	1.028	1.002	
6	Clark*	0.955*	1.046*	
6	Cowlitz	0.955	1.046	
6	Skamania*	0.955*	1.046*	
6	Wahkiakum*	0.955*	1.046*	
7	Adams	1.011	1.014	
7	Chelan	1.011	1.014	
7	Douglas	1.011	1.014	
7	Grant	1.011	1.014	
7	Okanogan	1.011	1.014	
8	Kittitas*	0.981*	1.003*	
8	Klickitat*	0.981*	1.003*	
8	Yakima	0.981	1.003	
9	Ferry*	1.044*	1.009*	
9	Lincoln	1.044	1.009	
9	Pend Orielle	1.044	1.009	
9	Stevens*	1.044*	1.009*	
10	Spokane	1.018	0.998	
11	Asotin*	1.021*	0.981*	
11	Garfield	1.021	0.981	
11	Whitman	1.021	0.981	
12	Benton	0.991	1.004	
12	Columbia	0.991	1.004	
12	Franklin	0.991	1.004	
12	Walla Walla	0.991	1.004	

*Note: Shaded areas are those not currently served.

2003 Ho Schip Contract
Exhibit D

Premiums, Service Areas and Capacity
Exhibit D-3 Service Area Detail
Contractor: Mhc
Effective January 1, 2002

Adams		Benton		Chelan		Clallam		Clark	
CITY	ZIP	CITY	ZIP	CITY	ZIP	CITY	ZIP	CITY	ZIP
Benge (50)	99105	Benton City	99320	Ardenvoir	98811	Beaver	98305	Amboy*	98601*
Cunningham	99327	Kennewick (U)	99336	Cashmere	98815	Carlsborg	98324	Battle Ground*	98604*
Hatton	99332	Kennewick	99337	Chelan	98816	Clallam Bay	98326	Bush Prairie*	98606*
Lind	99341	Kennewick	99338	Chelan Falls	98817	Forks	98331	Camas*	98607*
Othello	99344	Paterson	99345	Dryden	98821	Joyce	98343	Heison*	98622*
Washtucna (50)	99371	Plymouth (50)	99346	Entiat	98822	La Push	98350	La Center*	98629*
Ritzville	99169	Prosser	99350	Leavenworth	98826	Neah Bay (50)	98357	Ridgefield*	98642*
		Richland	99352	Malaga	98828	Port Angeles	98362	Vancouver*	98660*
		West Richland	99353	Manson	98831	Port Angeles	98363	Vancouver (U)*	98661*
				Monitor	98836	Sekiu (50)	98381	Vancouver*	98662*
				Peshastin	98847	Sequim	98382	Vancouver (U)*	98663*
				Stehekin (CP 65)	98852			Vancouver (U)*	98664*
				Wenatchee	98801			Vancouver*	98665*
				Wenatchee	98807			Vancouver*	98666*
								Vancouver*	98667*
								Vancouver*	98668*
								Vancouver*	98682*
								Vancouver*	98683*
								Vancouver (U)*	98684*
								Vancouver*	98685*
								Vancouver*	98686*
								Vancouver*	98687*
								Yacolt*	98675*
								Washougal*	98671*

Columbia	Cowlitz

CITY	ZIP	CITY	ZIP
Dayton	99328	Ariel (50)	98603
Starbuck	99359	Carrolls	98609
		Castle Rock	98611
		Cougar (50)	98616
		Kalama	98625
		Kelso	98626
		Longview	98632
		Ryderwood	98581
		Silverlake	98645
		Toutle	98649
		Woodland	98674

Exhibit D
Premiums, Service Areas and Capacity
Exhibit D-3, Service Area Detail
Contractor: MHC
Effective: January 1, 2003

Douglas		Ferry		Franklin		Garfield	
CITY	ZIP	CITY	ZIP	CITY	ZIP	CITY	ZIP
Bridgeport	98813	Boyd*	99107*	Connell	99326	Pomeroy	99347
East Wenatchee	98802	Curlew (50)*	99118*	Eltopia	99330		
Mansfield	98830	Danville (50)*	99121*	Kahlotus	99335		
Orondo	98843	Inchelium (50)*	99138*	Mesa	99343		
Palisades	98845	Keller*	99140*	Pasco	99301		
Rock Island	98850	Laurier (50)*	99146*	Pasco	99302		
Waterville	98858	Malo*	99150*				
		Orient*	99160*				
		Republic*	99166*				

Grant		Grays Harbor		Island		Jefferson	
CITY	ZIP	CITY	ZIP	CITY	ZIP	CITY	ZIP
Beverly	99321	Aberdeen*	98520*	Clinton	98236	Brinnon*	98320*
Coulee City	99115	Amanda Park*	98526*	Coupeville	98239	Chimacum*	98325*
Electric City	99123	Copalis Bch.*	98535*	Freeland	98249	Port Hadlock*	98339*
Ephrata	98823	Copalis Cros*	98536*	Greenbank	98253	Nordland*	98358*
George	98824	Cosmopolis*	98537*	Langley	98260	Port Ludlow*	98365*
Grand Coulee	99133	Elma*	98541*	Oak Harbor	98277	Port Townsend*	98368*
Hartline	99135	Grayland*	98547*	Oak Harbor	98278	Quilcene*	98376*
Marlin	98832	Hoquiam*	98550*				
Mattawa (50)	99349	Humptuliips*	98552*				
Moses Lake	98837	Malone*	98559*				
Quincy	98848	McCleary*	98557*				
Royal City	99357	Moclips*	98562*				
Soap Lake	98851	Montesano*	98563*				
Stratford	98853	Neilton*	98566*				
Warden	98857	Oakville*	98568*				
Wilson Creek	98860	Ocean Shores*	98569*				
		Pacific Bch.*	98571*				
		Quinault*	98575*				
		Satsop*	98583*				
		Taholah*	98587*				
		Westport*	98595*				

NOTES:

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2003 HO SCHIP Contract
Exhibit D

Premiums, Service Areas and Capacity
Exhibit D-3, Service Area Detail
Contractor: MHC
Effective: January 1, 2003

King

CITY	ZIP	CITY	ZIP	CITY	ZIP	CITY	ZIP
Auburn	98001	Kent	98042	Seattle (U)	98111	Seattle	98166
Auburn (U)	98002	Kent	98064	Seattle (U)	98112	Seattle	98168
Auburn	98071	Kirkland (U)	98033	Seattle (U)	98114	Seattle (U)	98170
Auburn	98092	Kirkland (U)	98034	Seattle (U)	98115	Seattle (U)	98171
Baring (50)	98224	Kirkland	98083	Seattle (U)	98116	Seattle (U)	98174
Bellevue	98004	Maple Valley	98038	Seattle (U)	98117	Seattle (U)	98177
Bellevue (U)	98005	Medina	98039	Seattle (U)	98118	Seattle (U)	98178
Bellevue	98006	Mercer Is. (U)	98040	Seattle (U)	98119	Seattle (U)	98181
Bellevue (U)	98007	North Bend	98045	Seattle (U)	98121	Seattle (U)	98184
Bellevue (U)	98008	Pacific (U)	98047	Seattle (U)	98122	Seattle (U)	98185
Bellevue	98009	Preston	98050	Seattle (U)	98124	Seattle	98188
Bellevue	98015	Ravensdale	98051	Seattle (U)	98125	Seattle (U)	98190
Black Diamond	98010	Redmond	98052	Seattle (U)	98126	Seattle (U)	98191
Bothell (U)	98011	Redmond	98053	Seattle (U)	98129	Seattle (U)	98195
Bothell	98041	Redmond	98073	Seattle (U)	98131	Seattle	98198
Burton	98013	Redmond	98074	Seattle (U)	98132	Seattle (U)	98199
Carnation	98014	Redondo	98054	Seattle (U)	98133	Skykomish (50)	98288
Duvall	98019	Renton	98055	Seattle (U)	98134	Snoqualmie	98065
Enumclaw (50)	98022	Renton (U)	98056	Seattle (U)	98136	Vashon	98070
Fall City	98024	Renton	98057	Seattle (U)	98138	Woodinville	98072
Federal Way (U)	98003	Renton	98058	Seattle (U)	98144	Bothell (U)	98012
Federal Way (U)	98023	Renton	98059	Seattle (U)	98145	Bothell (U)	98021
Federal Way	98063	Seahurst	98062	Seattle (U)	98146	Bothell (U)	98082
Federal Way	98093	Seattle (U)	98101	Seattle	98148	Snoqualmie Pass (50)	98068
Hobart	98025	Seattle (U)	98102	Seattle (U)	98151		
Issaquah	98027	Seattle (U)	98103	Seattle (U)	98154		
Issaquah	98029	Seattle (U)	98104	Seattle (U)	98155		
Kent	98030	Seattle (U)	98105	SeaTac (U)	98158		
Issaquah	98075	Seattle (U)	98106	Seattle (U)	98160		
Kenmore	98028	Seattle (U)	98107	Seattle (U)	98161		
Kent (U)	98031	Seattle (U)	98108	Seattle (U)	98164		
Kent	98032	Seattle (U)	98109				
Kent	98035						

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Effective: January 1, 2003

Kitsap		Kittitas		Klickitat		Lewis	
CITY	ZIP	CITY	ZIP	CITY	ZIP	CITY	ZIP
Bainbridge Is.	98110	CleElum*	98922*	Appleton*	98602*	Adna	98522
Bremerton (U)	98310	Easton*	98925*	Bickleton (50)*	99322*	Centralia	98531
Bremerton	98311	Ellensburg*	98926*	Bingen*	98605*	Chehalis	98532
Bremerton	98312	Kittitas*	98934*	Centerville*	98613*	Cinnabar	98533
Bremerton (U)	98314	Ronald*	98940*	Dallesport*	98617*	Curtis	98538
Bremerton	98337	Roslyn*	98941*	Glenwood (50)*	98619*	Doty	98539
Bremerton	98322	S. CleElum*	98943*	Goldendale*	98620*	Ethel	98542
Hansville	98340	Thorp*	98946*	Husum*	98623*	Galvin	98544
Indianola	98342	Vantage*	98950*	Klickitat*	98628*	Glennoma	98336
Keyport	98345			Lyle*	98635*	Mineral	98355
Kingston	98346			Roosevelt (50)*	99356*	Morton	98356
Manchester	98353			Trout Lake*	98650*	Mossyrock	98564
Ollala	98359			Wahkiacus*	98670*	Napavine	98565
Port Gamble	98364			White Salmon*	98672*	Onalaska	98570
Port Orchard	98366			Wishram*	98673*	Packwood (50)	98361
Port Orchard	98367					Pe Ell	98572
Poulsbo	98370					Randle (50)	98377
Retsil	98378					Salkum	98582
Rollingbay	98061					Silver Creek	98585
Seabeck	98380					Toledo	98591
Silverdale	98315					Vader	98593
Silverdale	98383					Winlock	98596
SouthColby	98384						
Southworth	98386						
Suquamish	98392						
Tracyton	98393						

Lincoln		Mason		Okanogan	
CITY	ZIP	CITY	ZIP	CITY	ZIP
Almira	99103	Allyn	98524	Brewster	98812
Creston	99117	Belfair	98528	Carlton	98814
Davenport	99122	Grapeview	98546	Conconully	98819
Edwall	99008	Hoodsport	98548	Coulee Dam	99116
Harrington	99134	Lilliwaup	98555	Elmer City	99124
Odessa	99144	Matlock	98560	Loomis	98827
Lincoln	99147	Shelton	98584	Malott	98829
Mohler	99154	Tahuya	98588	Mazama (50)	98833
Odessa	99159	Union	98592	Methow	98834
Reardan	99029			Nespelem	99155
Sprague (50)	99032			Okanogan	98840

Wilbur	99185	Omak	98841
		Oroville	98844
		Pateros	98846
		Riverside	98849
		Tonasket	98855
		Twisp (50)	98856
		Wauconda (50)	98859
		Winthrop (50)	98862

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Pacific		Pend Oreille		Pierce			
CITY	ZIP	CITY	ZIP	CITY	ZIP	CITY	ZIP
Bay Center	98527	Cusick (50)	99119	Anderson Is.	98303	South Prairie	98385
Chinook	98614	Ione (50)	99139	Ashford (50)	98304	Spanaway	98387
Illwaco	98624	Metaline (50)	99152	Buckley	98321	Steilacoom	98388
Lebam	98554	Metaline Falls (50)	99153	Camp Murray	98430	Sumner	98352
Long Beach	98631	Newport	99156	Carbonado	98323	Sumner	98390
Menlo	98561	Usk	99180	Dupont	98327	Tacoma (U)	98401
Nahcotta	98637			Eatonville	98328	Tacoma (U)	98402
Naselle	98638			Elbe	98330	Tacoma (U)	98403
Ocean Park	98640			Fox Island	98333	Tacoma (U)	98404
Oysterville	98641			Gig Harbor	98329	Tacoma (U)	98405
Raymond	98577			Gig Harbor	98332	Tacoma (U)	98406
Seaview	98644			Gig Harbor	98335	Tacoma (U)	98407
South Bend	98586			Graham	98338	Tacoma (U)	98408
Tokeland	98590			Kapowsin	98344	Tacoma (U)	98409
				La Grande	98348	Tacoma (U)	98411
				Lake Bay	98349	Tacoma (U)	98412
				Lakewood	98439	Tacoma (U)	98413
				Lakewood	98492	Tacoma (U)	98415
				Lakewood	98497	Tacoma (U)	98416
				Lakewood	98498	Tacoma (U)	98418
				Lakewood	98499	Tacoma	98421
				Longbranch	98351	Tacoma	98422
				Longmire	98397	Tacoma	98424
				McChord AFB	98438	Tacoma	98431
				McKenna	98558	Tacoma	98433
				Milton	98354	Tacoma	98442
				Orting	98360	Tacoma	98443
				Puyallup	98371	Tacoma (U)	98444
				Puyallup	98372	Tacoma (U)	98445
				Puyallup (U)	98373	Tacoma	98446
				Puyallup	98374	Tacoma (U)	98447
				Puyallup	98375	Tacoma (U)	98450
				Roy	98580		

Pierce		San Juan	
CITY	ZIP	CITY	ZIP
Tacoma (U)	98455	Deer Harbor	98243
Tacoma (U)	98460	Eastsound	98245
University Place (U)	98464	Friday Harbor	98250
Tacoma (U)	98465	Lopez Is.	98261

Tacoma (U)	98466	Olga	98279
Tacoma	98471	Orcas	98280
Tacoma	98477	Shaw Is.	98286
Tacoma	98481	Waldron	98297
Tacoma	98493	Blakley Island	98222
University Place	98467		
Vaughn	98394		
Wauna	98395		
Wilkeson	98396		
Paradise Inn	98398		

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Skagit		Skamania*		Snohomish		Spokane			
CITY	ZIP	CITY*	ZIP*	CITY	ZIP	CITY	ZIP	CITY	ZIP
Anacortes	98221	Carson*	98610*	Arlington*	98223*	Airway Hts.	99001	Spokane	99210
Bow	98232	N. Bonneville*	98639*	Darrington (50)*	98241*	Chattaroy	99003	Spokane	99211
Bow	98246	Stevenson*	98648*	Edmonds (U)	98020	Cheney	99004	Spokane	99212
Burlington	98233	Underwood*	98651*	Edmonds (U)	98026	Colbert	99005	Spokane	99213
Clear Lake	98235			Everett*	98201*	Deer Park	99006	Spokane	99214
Concrete (50)	98237			Everett*	98203*	Elk	99009	Spokane	99215
Conway	98238			Everett*	98204*	Fairchild AFB	99011	Spokane	99216
Hamilton	98255			Everett*	98205*	Fairfield	99012	Spokane	99217
La Conner	98257			Everett*	98206*	Four Lakes	99014	Spokane (U)	99218
Lyman	98263			Everett*	98207*	Freeman	99015	Spokane	99219
Marble Mount (50)	98267			Everett*	98208*	Greenacres	99016	Spokane	99220
Mt. Vernon	98273			Gold Bar*	98251*	Latah	99018	Spokane	99223
Mt. Vernon	98274			Granite Falls*	98252*	Liberty Lake	99019	Spokane	99224
Rockport (50)	98283			Index*	98256*	Marshall	99020	Spokane	99228
Sedro Wooley	98284			Lake Stevens*	98258*	Mead	99021	Spokane	99251
				Lynnwood (U)*	98036*	Medical Lake	99022	Spokane	99252
				Lynnwood (U)*	98037*	Mica	99023	Spokane	99256
				Lynnwood (U)*	98046*	Newman Lake	99025	Spokane	99258
				Marysville*	98270*	Nine Miles Falls	99026	Spokane	99260
				Marysville*	98271*	Otis Orchards	99027	Spokane	99299
				Monroe*	98272*	Rockford	99030	Valleyford	99036
				Mountlake Terrace (U)*	98043*	Spangle	99031	Veradale	99037
				Mukilteo*	98275*	Spokane (U)	99201	Waverly	99039
				N. Lakewood*	98259*	Spokane (U)	99202		
				Silvana*	98287*	Spokane (U)	99203		
				Snohomish*	98290*	Spokane (U)	99204		

Snohomish*	98291*	Spokane (U)	99205
Snohomish*	98296*	Spokane	99206
Stanwood*	98282*	Spokane (U)	99207
Stanwood*	98292*	Spokane	99208
Startup*	98293*	Spokane	99209
Sultan*	98294*		

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Stevens		Thurston		Wahkiakum		Walla Walla		Whatcom	
CITY	ZIP	CITY	ZIP	CITY	ZIP	CITY	ZIP	CITY	ZIP
Addy*	99101*	Bucoda	98530	Cathlamet*	98612*	Burbank	99323	Acme	98220
Chewelah*	99109*	East Olympia	98540	Grays River*	98621*	College Place	99324	Bellingham (U)	98225
Clayton*	99110*	Lacey	98503	Rosburg*	98643*	Dixie	99329	Bellingham	98226
Colville*	99114*	Lacey	98509	Skamokawa*	98647*	Prescott (50)	99348	Bellingham	98227
Evans*	99126*	Littlerock	98556			Touchet	99360	Bellingham	98228
Ford*	99013*	Olympia	98501			Walla Walla	99362	Bellingham	98229
Fruitland*	99129*	Olympia	98502			Wallula	99363	Blaine	98230
Gifford*	99131*	Olympia	98504			Waitsburg	99361	Blaine	98231
Hunters (50)*	99137*	Olympia	98505					Custer	98240
Kettle Falls (50)*	99141*	Olympia	98506					Deming	98244
Loon Lake*	99148*	Olympia	98507					Everson	98247
Marcus*	99151*	Olympia	98508					Ferndale	98248
Northport (50)*	99157*	Olympia	98512					Lummi Is.	98262
Rice*	99167*	Olympia	98513					Lynden	98264
Springdale*	99173*	Olympia	98516					Maple Falls	98266
Tumtum*	99034*	Olympia	98599					Nooksack	98276
Valley*	99181*	Rainier	98576					Pt. Roberts	98281
Wellpinit*	99040*	Rochester	98579					Sumas	98295
		Tenino	98589						
		Tumwater	98511						
		Yelm	98597						

Whitman		Yakima	
CITY	ZIP	CITY	ZIP
Albion	99102	Brownstown*	98920*
Belmont	99104	Buena	98921
Colfax	99111	Cowiche*	98923*
Colton	99113	Goose Prairie*	98929*
Endicott	99125	Grandview	98930
Farmington	99128	Granger	98932
Garfield	99130	Harrah*	98933*
Hay	99136	Mabton	98935
Hooper	99333	Moxee*	98936*
LaCross	99143	Naches (50)*	98937*
Lamont	99017	Outlook	98938
Malden	99149	Parker*	98939*

Oakesdale	99158	Selah	98942
Palouse	99161	Sunnyside	98944
Pullman	99163	Tieton*	98947*
Pullman	99164	Toppenish	98948
Pullman	99165	Wapato*	98951*
Rosalia	99170	White Swan*	98952*
St John	99127	Yakima	98901
St. John	99171	Yakima (U)	98902
Steptoe	99174	Yakima	98903
Tekoa	99033	Yakima*	98904*
Thornton	99176	Yakima*	98907*
Uniontown	99179	Yakima*	98908*
		Yakima*	98909*
		Zillah	98953

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EXHIBIT E
CHAPTER 388-542 WAC
CHILDREN'S HEALTH INSURANCE PLAN (CHIP)

WAC 388-542-0050 DEFINITIONS FOR CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) TERMS. The following definitions and abbreviations, those found in WAC 388-538-050 and in 388-500-0005 Medical definitions, apply to this chapter.
"CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)" means the health insurance program authorized by Title XXI of the Social Security Act and administered by the department of social and health services (DSHS). This program also is referred to as the state children's health insurance program (SCHIP).
"CLIENT PREMIUM" means a monthly payment a client makes to the department of social and health services (DSHS) for CHIP coverage.
"CREDITABLE COVERAGE" means most types of public and private health coverage, except Indian health services, that provides access to physicians, hospitals, laboratory services, and radiology services. This term applies to the coverage whether or not the coverage is equivalent to that offered under CHIP. "Creditable coverage" is described in 42 U.S.C. Sec. 1397jj.
"EMPLOYER-SPONSORED DEPENDENT COVERAGE" means creditable health coverage for dependents offered by a family member's employer or union, for which the employer or union may contribute in whole or part towards the premium. Extensions of such coverage (e.g., COBRA extensions) also qualify as employer-sponsored dependent coverage as long as there remains a contribution toward the premiums by the employer or union.
"FINANCE DIVISION" means the division of the department of social and health services that sends out billing statements, monitors accounts, and collects the CHIP client premiums.

WAC 388-542-0100 CHIP SCOPE OF CARE. (1) Children's health insurance program (CHIP) clients are eligible for the same scope of medical care as Medicaid categorically needy clients as described in WAC 388-529-0100.
(2) The medical assistance administration (MAA) requires CHIP clients, except for clients who are American Indian or Alaska Native (AI/AN), to enroll in managed care according to WAC 388-538-060(1)(b) through (5)(d). AI/AN clients may choose to receive services under MAA's fee-for-service system.
(3) For eligible CHIP clients who are not enrolled in managed care:
(a) MAA determines which services are medically necessary;
(b) Clients must obtain covered services from providers who have core provider agreements with MAA; and
(c) As a condition of coverage, MAA may require the service provider to obtain authorization from MAA for coverage of nonemergency services.
(4) A CHIP client enrolled in managed care may submit a complaint or appeal as described in WAC 388-538-110.
(5) Any CHIP client may request a fair hearing as described in chapter 388-02 WAC for

review of MAA coverage decisions. Clients may elect to participate in a pre-hearing review as described in WAC 388-526-2610.

WAC 388-542-0125 ACCESS TO CARE. (1) If a children's health insurance program (CHIP) client is subject to mandatory enrollment in a managed care organization (MCO) or with a primary care case management (PCCM) provider, the medical assistance administration (MAA) provides fee-for-service coverage between the time a client becomes eligible for CHIP services and the time the client is enrolled in managed care.
(2) Not all CHIP clients are required to enroll in an MCO or with a PCCM provider. The same enrollment criteria are applied to CHIP clients as to categorically needy Medicaid clients under WAC 388-538-060.
(3) If a CHIP client is not already enrolled in managed care, the client may request an exemption to mandatory enrollment under the process described in WAC 388-538-080. MAA provides fee-for-service coverage while a client's request for exemption from mandatory enrollment in an MCO or with a PCCM provider is being considered and until a final decision is made.
(4) If a CHIP client is already enrolled in an MCO or with a PCCM provider and requests to end the enrollment, the client remains enrolled in the client's MCO or with the PCCM provider pending MAA's final decision. The process for ending enrollment is described in WAC 388-538-130.
(5) If a CHIP client has no MCO or PCCM provider available or is permitted to choose the fee-for-service system under this chapter, the rules that apply to service coverage and payment for the children's health program apply to CHIP coverage (chapters 388-550 through 388-556 WAC).

WAC 388-542-0150 CLIENT ELIGIBILITY REQUIREMENTS FOR CHIP. (1) To be eligible for the children's health insurance program (CHIP) a client must meet all of the following. The client must:
(a) Not have other creditable coverage (see WAC 388-542-0220(1)); and
(b) Meet the CHIP program requirements and conditions in WAC 388-505-0210(3).
(2) There are no resource standards for a CHIP client. See WAC 388-478-0075(3).
(3) CHIP eligibility certification periods are described in WAC 388-416-0015.
(4) CHIP eligibility is affected by changes in a client's circumstances. See WAC 388-418-0025(2) and (6).
(5) Ongoing eligibility for CHIP requires the payment of CHIP premiums as described in WAC 388-542-0250. MAA enrolls an otherwise eligible client into the CHIP program in advance of any client premium payment.

WAC 388-542-0200 CHIP ENROLLMENT. (1) If the area in which a CHIP client lives has more than one service delivery option available to the client, the client must make a choice concerning how to receive health care services. The choice and enrollment process for CHIP clients is the same as that for categorically needy Medicaid clients described in WAC 388-538-060.
(2) The medical assistance administration (MAA) enrolls CHIP clients in MAA's managed care program (with a managed care organization (MCO) or with a primary care case management (PCCM) provider) prospectively only.

(3) CHIP clients are enrolled in managed care as provided for categorically needy Medicaid clients in WAC 388-538-060.
(4) A client who is required to enroll in managed care may request a change in the client's MCO or PCCM provider on the same bases as in WAC 388-538-060.

WAC 388-542-0220 ENDING CHIP CLIENT ELIGIBILITY. (1) If the medical assistance administration (MAA) finds out after eligibility determination that a CHIP client has creditable coverage at the time of application, MAA ends the client's eligibility for CHIP effective at the close of the last day of the current month.
(2) MAA ends a client's eligibility for CHIP when the client owes four consecutive months of premiums, based on the due dates listed on the billing from the finance division for the client premium(s).
(3) When MAA ends a client's eligibility according to subsection (2) of this section, a client must meet both of the following conditions to become eligible for CHIP again:
(a) Pay all unforgiven past due premiums (see WAC 388-542-0250(5); and
(b) Serve a waiting period of four consecutive months. The waiting period begins the day after termination of CHIP coverage for nonpayment of premiums as described in this section. The waiting period ends once four full consecutive months of CHIP noncoverage has elapsed. The client does not have CHIP coverage during the waiting period.

WAC 388-542-0250 CHIP CLIENT COSTS. (1) The finance division charges ten dollars per covered child, per month, for the CHIP client premium. The family maximum for CHIP premiums is thirty dollars per month.
(2) The finance division sends bills for client premiums at the beginning of each month of coverage. Client premiums begin the first of the month in which the bill was sent, not the date that the client became eligible for services.
(3) MAA limits a client's out-of-pocket expenses for covered services the client obtains under the CHIP program rules, to the payment of premiums described in subsection (1) if this section.
(4) MAA exempts American Indian/Alaska Native (AI/AN) clients from paying client premiums for coverage under the CHIP program.
(5) MAA forgives client premiums that are more than twelve months overdue.

WAC 388-542-0275 REIMBURSEMENT. (1) For contractors serving CHIP clients enrolled in managed care, MAA reimburses contracted managed care organizations (MCOs), primary care case management (PCCM) providers and providers of approved or ancillary care in the same way as described in chapter 388-538 WAC.
(2) For providers of services serving CHIP clients under MAA's fee-for-service system and without the involvement of MCOs or PCCMs, MAA reimburses according to the regulations that apply to categorically needy Medicaid clients under chapters 388-500 through 388-556 WAC.

WAC 388-542-0300 WAITING PERIOD FOR CHIP COVERAGE FOLLOWING EMPLOYER COVERAGE.
(1) The medical assistance administration (MAA) requires applicants to serve a full four-consecutive-month waiting period for CHIP coverage if the client or

family:
(a) Chooses to end employer sponsored dependent coverage. The waiting period begins the day after the employment-based coverage ends, and ends on the last day of the fourth full month of noncoverage; or
(b) Fails to exercise an optional coverage extension (e.g., COBRA) that meets the following conditions. The waiting period begins on the day there is a documented refusal of the coverage extension when the extended coverage is:
(i) Subsidized in part or in whole by the employer or union;
(ii) Available and accessible to the applicant or family; and
(iii) At a monthly cost to the family meeting the limitation of subsection (2)(b)(iv).
(2) MAA does not require a waiting period prior to CHIP coverage when:
(a) The client or family member has a medical condition that, without treatment, would be life-threatening or cause serious disability or loss of function; or
(b) The loss of employer sponsored dependent coverage is due to any of the following((;)):
(i) Loss of employment with no post-employment subsidized coverage as described in subsection (1)(b);
(ii) Death of the employee;
(iii) The employer discontinues employer-sponsored dependent coverage;
(iv) The family's total out-of-pocket maximum for employer-sponsored dependent coverage is fifty dollars per month or more;
(v) The plan terminates employer-sponsored dependent coverage for the client because the client reached the maximum lifetime coverage amount;
(vi) Coverage under a COBRA extension period expired;
(vii) Employer-sponsored dependent coverage is not reasonably available (e.g., client would have to travel to another city or state to access care); or
(viii) Domestic violence caused the loss of coverage for the victim.

WAC 388-542-0500 MANAGED CARE RULES THAT APPLY TO CHIP. (1) In addition to the other rules that are incorporated by reference elsewhere in this chapter, the medical assistance administration (MAA) applies the following rules from chapter 388-538 WAC to the CHIP program:
(a) WAC 388-538-060, Managed care and choice, with the exception of subsection (1)(a);
(b) WAC 388-538-070, Managed care payment;
(c) WAC 388-538-080, Managed care exemptions;
(d) WAC 388-538-095, Scope of care for managed care enrollees;
(e) WAC 388-538-100, Managed care emergency services;
(f) WAC 388-538-110. Managed care complaints, appeals and fair hearings;
(g) WAC 388-538-120, Enrollee requests for a second medical opinion;
(h) WAC 388-538-130, Ending enrollment in healthy options; and
(i) WAC 388-538-140, Quality of care.

EMPLOYMENT AGREEMENT

This Employment Agreement (this "Agreement") is made as of January 2, 2002, between Joseph M. Molina, MD ("Executive") and Molina Healthcare, Inc. (the "Company").

RECITALS

The Company desires to establish its right to the services of Executive in the capacities described below, on the terms and conditions hereinafter set forth, and Executive is willing to accept such employment on such terms and conditions. The parties hereto have previously entered into an Employment Agreement dated May 1,1997 (the "Existing Agreement"), and this Agreement supercedes the Existing Agreement.

AGREEMENT

The parties agree as follows:

1. DUTIES

(a) The Company does hereby hire, engage, and employ Executive as Chief Executive Officer of the Company, and Executive does hereby accept and agree to such hiring, engagement, and employment. During the Period of Employment (as defined in Section 2), Executive shall serve the Company in such position in conformity with the provisions of this Agreement, directives of the Board of Directors and the corporate policies of the Company as they presently exist, and as such policies may be amended, modified, changed, or adopted during the Period of Employment. Executive shall have duties and authority consistent with Executive's position as Chief Executive Officer and shall report to the Board of Directors of the Company (the "Reporting Relationship").

(b) Throughout the Period of Employment, Executive shall devote his time, energy, and skill to the performance of his duties for the Company, vacations and other leave authorized under this Agreement excepted. Notwithstanding the foregoing, Executive shall be permitted to (i) engage in charitable and community affairs and (ii) make direct investments of any character in any non-competing business or businesses and to manage such investments (but not be involved in the day-to-day operations of any such business); provided, in each case, and in the aggregate, that such activities do not materially interfere with the performance of Executive's duties hereunder, and further provided that Executive may invest in a publicly traded competing business so long as such investment does not equal or exceed one percent of the outstanding shares of such publicly traded competing business.

(c) Executive hereby represents to the Company that the execution and delivery of this Agreement by Executive and the Company and the performance by Executive of Executive's duties hereunder shall not constitute a breach of, or otherwise contravene, the terms of any employment or other agreement or policy to which Executive is a party or otherwise bound.

2. PERIOD OF EMPLOYMENT

The "Period of Employment" shall, unless sooner terminated as provided herein, be a period commencing on January 1, 2002 (the "Effective Date") and ending with the close of business on December 31,2004. Notwithstanding the preceding sentence, commencing with January 1, 2005 and on each January 1st thereafter (each an "Extension Date"), the Period of Employment shall be automatically extended for an additional one-year period so as to expire one year from such Extension Date, unless: (i) the Company or Executive provides the other party hereto ninety (90) days' prior written notice before the next scheduled Extension Date that the Period of Employment shall not be so extended (the "Non-Extension Notice"); or (ii) Executive is not less than sixty-five (65) years of age as of the next scheduled Extension Date. The term "Period of Employment" shall include any extension that becomes applicable pursuant to the preceding sentence.

3. COMPENSATION

(a) BASE SALARY. Executive's Base Salary shall be at a rate of not less than $500,000 annually ("Executive's Base Salary"), paid in accordance with regular payroll practices, but not less than monthly. The Board of Directors shall review at least annually Executive's Base Salary for possible increase in accordance with the Company's customary review practices for its senior executives and may, in his sole discretion, periodically adjust Executive's Base Salary to reflect individual performance. In the event of an increase, Executive's Base Salary for the year in which the increase occurs shall be adjusted on a pro rata basis to reflect the increase.

(b) BONUS. Executive shall be eligible to earn an annual discretionary bonus for each fiscal year of the Company (an "Annual Bonus") as described in the Addendum.

4. BENEFITS

(a) HEALTH AND WELFARE. During the Period of Employment, Executive shall be entitled to participate, on the same terms and at the same level as other executives, in all health and welfare benefit plans and programs generally available to other executives or employees of the Company (including, without limitation, the Company's medical, dental, vision, life benefits, life insurance, and long-term disability plans) as in effect from time to time and to receive any special benefits provided from time to time, subject to any legally required restrictions specified in such plans and programs. Without limiting the generality of the foregoing, Company shall provide life insurance for Executive, with Executive to designate the beneficiary thereunder, in an amount equal to Executive's Base Salary as in effect on the date of this Agreement and as in effect on the first business day of each calendar year thereafter.

(b) PAID TIME OFF AND OTHER LEAVE. During the Period of Employment, Executive shall receive 10.77 hours of paid time off per "pay period" of the Company (the "PTO"), subject to the Company's policies concerning accrual of PTO and provided that for any three hundred sixty five (365) day period within the Period of Employment Executive shall earn no less than a total of thirty five (35) days of PTO. Executive shall also be entitled to all other holiday and leave pay generally available to other executives of the Company.

(c) TRAVEL AND EXPENSE REIMBURSEMENTS. During the Period of Employment, Company will reimburse Executive for all reasonable expenses incurred in connection with performance of his duties under section 1 of this Agreement in accordance with the Company's expense reimbursement policies.

(d) RETIREMENT. During the Period of Employment, Executive shall be eligible to participate on the same terms and at the same level as other executives, in all retirement, 401(k), deferred compensation, or other savings plans generally available to other executives, or employees of the Company as in effect from time to time, subject to any legally required restrictions specified in such plans and programs.

(e) EQUITY GRANTS.

(i) Existing Options. Executive holds on the Effective Date options for zero shares of common stock of the Company (the "Existing Options"). The Existing Options are subject to the terms and conditions of the Employment Agreement and shall hereafter continue to be subject to and controlled by the terms and conditions of the Employment Agreement.

(ii) Initial Options. Executive shall, on the Effective Date, be granted stock options for sixty five hundred (6500) shares of the common stock of the Company (the "Initial Options") pursuant to an option agreement The exercise price of the Initial Options will be $ 180 per share. The Initial Options are subject to the terms and conditions of the "Molina Healthcare, Inc. Amended and Restated Stock Incentive Plan" (the "Restated Option Plan").

(iii) Future Options. Executive shall be eligible, at the sole discretion of the Board, for additional annual stock option grants (the "Future Options") pursuant to one or more additional option agreements. Any Future Options will be granted under and subject to the terms and conditions of a stock option plan of the Company as then in effect (as of the date of any grant, an "Effective Option Plan"). The terms and conditions of such Future Options are intended to be such that Executive shall receive a compensation package commensurate with executives performing the same functions as Executives for businesses similar to the Company.

(f) OTHER BENEFITS. In addition to benefits specifically provided herein, during the Period of Employment, Executive shall be entitled to participate, on the same terms and at the same level as other executives, in all fringe benefit plans and perquisites provided by Company to its executives.

The employee benefits described in Sections 4(a) through (f) inclusive are referred to as "Executive Benefits."

5. DEATH OR DISABILITY

(a) PERMANENTLY DISABLED AND PERMANENT DISABILITY. The terms "Permanently Disabled" and "Permanent Disability" shall mean Executive's inability, because of physical or mental illness or injury, to perform the essential functions of his customary duties pursuant to this Agreement, with or without reasonable accommodation, and the continuation of such disabled condition for a period of twelve (12) months.

(b) TERMINATION DUE TO DEATH OR DISABILITY. If Executive dies or becomes Permanently Disabled during the Period of Employment, the Period of Employment and Executive's employment shall automatically cease and terminate as of the date of Executive's death or the date of Permanent Disability as determined by the Board (which date shall be referred to as the "Disability Date"), as the case may be. In the event of the termination of the Period of Employment and Executive's employment hereunder due to Executive's death or Permanent Disability, Executive or his estate shall be entitled to receive:

(i) Within five (5) business days, a lump sum cash payment equal to the sum of (x) any accrued but unpaid Base Salary and PTO as of the Termination Date hereunder and (y) any unpaid annual incentive compensation in respect of the most recently completed fiscal year preceding the Termination Date (the "Unpaid Annual Bonus"); and

(ii) Within thirty (30) days, such employee benefits described in Sections 4(a) and 4(c) through 4(f) inclusive, if any, as to which Executive may be entitled as of the Termination Date under the employee benefit plans and arrangements of the Company ((i) and (ii) collectively, the "Accrued Obligations").

6. TERMINATION BY THE COMPANY

(a) TERMINATION FOR CAUSE. The Company may terminate for Cause (as defined below) at any time the Period of Employment and Executive's employment hereunder by providing to Executive written notice of such termination ("Notice of Termination for Cause"). The term "Cause" shall mean a termination of service based upon a finding by the Company, acting in good faith and based on its reasonable belief at the time, that Executive:

(i) has engaged in unlawful acts involving moral turpitude or gross negligence with respect to the Company;

(ii) has consistently and willfully failed to perform his duties or has intentionally breached any material provision of any agreement with the Company or an affiliated entity; provided, however, that such failure or breach shall not constitute Cause unless it is (A) not reasonably curable or (B) if reasonably curable, is not cured by the Executive within thirty (30) days notice from the Company;

If the Executive's employment is terminated for Cause, the termination shall take effect on the Termination Date (as defined below). In the event of termination of the Period of Employment and Executive's employment hereunder due to a termination by the Company for Cause, Executive shall be entitled to receive the Accrued Obligations. All of the Accrued Obligations shall be paid on the Termination Date except those benefits described in Sections 4(a) and 4(c) through (f) inclusive, which shall be paid within thirty (30) days of the Termination Date.

If the Company attempts to terminate Executive's employment pursuant to this Section 6(a) and it is ultimately determined that the Company lacked Cause, the provisions of Section 6(b) ("Termination by the Company-Termination Without Cause") shall apply as if the Company had provided Executive with Notice of Termination Without Cause (as defined below) on the date the Company actually provided Executive with Notice of Termination for Cause.

(b) TERMINATION WITHOUT CAUSE. The Company may, without cause or reason, terminate at any time the Period of Employment and Executive's employment hereunder by providing Executive written notice of such termination ("Notice of Termination Without Cause"). A Non-Extension Notice by the Company shall be considered a termination without Cause. If Executive's employment is terminated without Cause, the termination shall take effect on the Termination Date. In the event of the termination of Executive's employment hereunder due to a termination by the Company without Cause (other than due to Executive's death or Permanent Disability):

(i) Executive shall be entitled to receive: (1) an amount equal to 100% of the sum of (x) Executive's Base Salary then in effect as of the Termination Date and (y) the Target Bonus for the fiscal year in which Executive's employment is terminated (the "Severance Payment"); (2) a pro rata portion of the Target Bonus for the fiscal year in which Executive's employment is terminated, based on the number of entire months of such fiscal year that have elapsed through the date of Executive's termination of employment as a fraction of twelve (12) (the "Pro Rata Bonus"); (3) the Accrued Obligations; (4) the entirety of Executive's contributions and the Company's contributions to Executive's 401(k) plan account as if Executive were fully vested as of the Termination Date, and (5) all other benefits under the welfare benefit and retirement plans contemplated by Sections 4(a) and 4(d) (the "Selected Benefits") until the earlier of (A) Executive's receipt of benefits substantially similar in scope and nature from another employer or (B) one year and one-half year after the Termination Date.

(ii) Executive shall be entitled to one hundred percent vesting of all of the options (including, without limitation, Existing Options, Initial Options, and Future Options) to purchase common stock of the Company ("Common Stock") held by Executive as of the Termination Date (the "Options") and/or right to the difference in cash between the fair market value and the exercise price of each vested but unexercised option.

(iii) Company shall, upon the written request of Executive (the "Executive Put Option") be required to repurchase all shares of Common Stock acquired by Executive pursuant to the exercise of stock options granted to and/or held by Executive as of the Termination Date (the "Executive Shares"). Executive may not exercise the Executive Put Option with respect to Executive Shares within the six-month period following the date Executive acquired such Executive Shares, and the Executive Put Option may not be exercised at any time after the Company becomes publicly traded. The repurchase price for each Executive Share shall be equal to the fair market value of a share of Common Stock ("Fair Market Value"), which Fair Market Value:

(A) shall be determined as of the date of the exercise of Executive Put Option by an independent appraiser chosen by the Company and Executive as follows: the Company shall identify three appraisers independent of the Company, and Executive shall select one from the three identified; and

(B) shall be determined without any minority, illiquidity or other discount.

(iv) Amounts payable under this Section 6(b) shall be payable as follows:

(A) amounts payable under clause (i) shall be, or shall commence to be, paid within 30 days following the Termination Date either in a single lump sum or in regular installments as a continuation of Executive's salary according to the Company's customary payroll practices, as determined by the Executive in his sole discretion; provided however that any amounts representing accrued but unpaid Executive Base Salary, PTO an Unpaid Annual Bonus shall be paid on the Termination Date.

(B) amounts payable under clause (iii) that are attributable to the exercise of Existing Options and/or Initial Options shall be paid by the Company in accordance with the terms and conditions of the Option Plan. Amounts payable under clause (iii) that are attributable to the exercise of Future Options shall be paid by the Company in three annual lump sum installments as follows: (1) within 30 days after the Termination Date, one-third of the payout; (2) on the first anniversary of the Termination Date, one-third of the payout, with interest on the previously unpaid portion of the payout accrued from the Termination Date at the applicable federal rate; and (3) on the second anniversary of the Termination Date, the remaining one-third of the payout, with interest on such previously unpaid portion of the payout accrued from the first anniversary of the Termination Date at the applicable federal rate.

Executive shall have no duty to mitigate damages and none of the payments provided in this Section 6(b) shall be reduced by any amounts earned or received by Executive from a third party at any time.

7. TERMINATION BY EMPLOYEE

(a) TERMINATION WITHOUT GOOD REASON. Executive shall have the right to terminate the Period of Employment and Executive's employment hereunder at any time without Good Reason (as defined below) upon fifteen (15) days prior written notice of such termination to the Company. A Non-Extension Notice by Executive shall be considered a termination without Good Reason. Any such termination by Executive without Good Reason shall be treated for all purposes of this Agreement as a termination by the Company for Cause and the provisions of Section 6(a) shall apply, provided, however, that notwithstanding the foregoing, if Executive terminates the Period of Employment without Good Reason, Executive shall be allowed to exercise the Executive Put Option with respect to Executive Shares received pursuant to the exercise of Existing Options, subject to the terms and conditions generally applicable with respect to the Executive Put Option.

(b) TERMINATION WITH GOOD REASON. Executive may terminate the Period of Employment and resign from employment hereunder for "Good Reason." "Good Reason" shall mean (with or without regard to whether a Change in Control Event has occurred), without obtaining Executive's prior written consent thereto:

(i) a material and adverse change in Executive's position, duties, responsibilities, Reporting Relationship or status with the Company,

(ii) a change in Executive's office location to a point more than fifty (50) miles from Executive's current office,

(iii) the taking of any action by the Company to: (A) eliminate benefit plans applicable to Executive without providing substitutes which provide a substantially similar aggregate value of benefits, (B) materially reduce Executive's benefits thereunder or (C) substantially diminish the aggregate value to Executive of incentive awards or other fringe benefits, provided, however, that it shall not constitute Good Reason for the Company to, as part of an overall cost-reduction program, take any action described in (A) - (C) so long as such action is taken with respect to all senior executives and Executive is not disproportionately affected thereby,

(iv) any reduction in the Base Salary, provided, however, that it shall not constitute Good Reason for the Company to, as part of an overall cost-reduction program, reduce Executive's Base Salary so long as the base salaries of all other senior executives are simultaneously reduced by not less than the same percentage, or

(v) any breach of this Agreement by the Company or any successor thereto, including without limitation any failure by the Company to obtain the consent of any Successor Entity (as defined below) to the provisions contained in Section 9; provided, however, that none of the events described in clause (v) of this Section 7(b) shall constitute Good Reason unless Executive shall have notified the Company in writing describing the events which constitute Good Reason and then only if the Company shall have failed to cure such event within thirty (30) days after the Company's receipt of such written notice.

Any such termination by Executive for Good Reason shall be treated for all purposes of this Agreement as a termination by the Company without Cause and the provisions of Section 6(b) shall apply; provided, however, that if Executive attempts to resign for Good Reason pursuant to this Section 7(b) and it is ultimately determined that Good Reason did not exist, Executive shall be deemed to have resigned from employment without Good Reason and the provisions of Section 7(a) and, by reference therein, the provisions of Section 6(a), shall apply.

8. TERMINATION DATE

The term "Termination Date" shall mean (i) if Executive's employment is terminated by the Company for Cause, or by Executive for Good Reason, the effective date (pursuant to Section 25 ("Notices")) of written notice of such termination to Executive or to the Company, as the case may be; (ii) if Executive's employment is terminated by the Company other than for Cause or Disability, the date on which the Company notifies Executive of such termination; or (iii) if Executive's employment is terminated by reason of Death or Disability, the Disability Date.

9. CHANGE IN CONTROL

(a) Notwithstanding anything to the contrary in this Agreement, if a Change in Control Event (as defined below) of the Company occurs during the term of this Agreement, and if within two years following such Change in Control Event either (1) the Company terminates Executive's employment without Cause or (2) Executive terminates his employment for Good Reason:

(i) the Company shall pay to Executive an amount equal to the sum of (w) two times the Severance Payment, (x) the Pro Rata Bonus, (y) the Accrued Obligations and (z) the entirety of Executive's contributions and the Company's contributions to Executive's 401(k) plan account as if Executive were fully vested as of the Termination Date, such amount to be, or to commence to be, paid on the Termination Date either in a single lump sum or in regular installments as a continuation of Executive's salary according to the Company's customary payroll practices, as determined by the Executive in his sole discretion at the time of termination. This payment shall be in lieu of the payment otherwise payable under clause (i) of Section 6(b).

(ii) the Company shall continue to provide the Selected Benefits until the earlier of (x) Executive's receipt of benefits substantially similar in scope and nature from another employer or (y) three years after the Termination Date.

(iii) and, regardless of whether any of the Options have been assumed by any Successor Entity, the provisions of clauses (ii) and (iii) of Section 6(b) will apply.

(iv) upon a change in control all unassumed and unvested options shall vest immediately.

(b) A "Change in Control Event" shall mean any of the following:

(i) Approval by the Board and by shareholders of the Company (or, if no shareholder approval is required, by the Board alone) of the dissolution or liquidation of the Company, other than in the context of a transaction that does not constitute a Change in Control Event under clause (ii) below;

(ii) Consummation of a merger, consolidation, or other reorganization, with or into, or the sale of all or substantially all of the Company's business and/or assets as an entirety to, one or more entities that are not Subsidiaries or other affiliates of the Company (a "Business Combination"), unless (1) as a result of the Business Combination, more than fifty percent (50%) of the outstanding voting power generally in the election of directors of the surviving or resulting entity or a parent thereof (the "Successor Entity") immediately after the reorganization is, or will be, owned, directly or indirectly, by holders of the Company's voting securities immediately before the Business Combination; and (2) no "person" (as such term is used in Sections 13(d) and 14(d) of the Exchange Act), excluding the Successor Entity or an Excluded Person, beneficially owns, directly or indirectly, more than fifty percent (50%) of the outstanding shares or the combined voting power of the outstanding voting securities of the Successor Entity, after giving effect to the Business Combination, except to the extent that such ownership existed prior to the Business Combination; or

(iii) Any "person" (as such term is used in Sections 13(d) and 14(d) of the Exchange Act) other than an Excluded Person: (a) becomes the beneficial owner (as defined in Rule 13d-3 under the Exchange Act), directly or indirectly, of securities of the Company representing more than fifty percent (50%) of the combined voting power of the Company's then outstanding securities entitled to then vote generally in the election of directors (the "Voting Power") of the Company (a "Majority Holder"), other than as a result of (1) an acquisition directly from the Company, (2) an acquisition by the Company, or (3) an acquisition by an entity pursuant to a transaction which is expressly excluded under clause (ii) above (an "Excluded Transaction"); or (b) provided that the beneficial owner of a majority of the Voting Power as of the Effective Date is no longer a Majority Holder, becomes the beneficial owner (as defined in Rule 13d-3 under the Exchange Act), directly or indirectly, of securities of the Company representing more than thirty percent (30%) of the Voting Power, other than as a result of an Excluded Transaction.

(iv) For the purposes of this Section 9(c):

(A) "Exchange Act" shall mean the Securities Exchange Act of 1934, as amended from time to time.

(B) "Excluded Person" shall mean (a) any person described in and satisfying the conditions of Rule 13d-l(b)(l) under the Exchange Act, (b) the Company, (c) an employee benefit plan (or related trust) sponsored or maintained by the Company or the Successor Entity, or (d) any person who is the beneficial owner (as defined in Rule 13d-3 under the Exchange Act) of more than [25%] of the Common Stock on the Effective Date (or an affiliate, successor, heir, descendant, or related party of or to such person).

(C) "Subsidiary" shall mean any corporation or other entity a majority of whose outstanding voting stock or voting power is beneficially owned, directly or indirectly, by the Company.

(c) Executive shall have no duty to mitigate damages and none of the payments provided in this Section 9 shall be reduced by any amounts earned or received by Executive from a third party at any time. Notwithstanding anything to the contrary in this Section 9, if, in connection with a Change in Control Event, Executive voluntarily enters a new written employment agreement with the Company or the Successor Entity, Executive may no longer rely upon the provisions of this Section 9.

10. CONFIDENTIALITY

Executive will not at any time (whether during or after his employment with the Company), unless compelled by lawful process, disclose or use for his own benefit or purposes or the benefit or purposes of any other person, firm, partnership, joint venture, association, corporation or other business organization, entity or enterprise other than the Company and any of its subsidiaries or affiliates, any trade secrets, or other confidential data or information relating to customers, development programs, costs, marketing, trading, investment, sales activities, promotion, credit and financial data, financing methods, or plans of the Company or of any subsidiary or affiliate of the Company; provided that the foregoing shall not apply to information which is not unique to the Company or which is generally known to the industry or the public other than as a result of Executive's breach of this covenant. Executive agrees that upon termination of his employment with the Company for any reason, he will return to the Company immediately all memoranda, books, papers, plans, information, letters and other data, and all copies thereof or therefrom, in any way relating to the business of the Company and its affiliates, except that he may retain personal notes, notebooks and diaries that do not contain confidential information of the type described in the preceding sentence. Executive further agrees that he will not retain or use for his account at any time any trade names, trademark or other proprietary business designation used or owned in connection with the business of the Company or its affiliates.

11. NON-SOLICITATION AND NON-DISPARAGEMENT

During the Period of Employment and for a period of eighteen (18) months thereafter, Executive will not, directly or indirectly: (a) solicit or attempt to solicit any employee of the Company to terminate his or her relationship with the Company in order to become an employee, consultant or independent contractor to or for any other person or business entity; (b) solicit customers, suppliers or clients of the Company to reduce or discontinue their business with the Company or to engage in business with any competing entity; (c) disparage the Company, its business, or its reputation; or (d) otherwise disrupt or interfere with business relationships (whether formed before or after the date of this Agreement) between the Company or any of its affiliates and customers, suppliers, partners, members or investors of the Company or its affiliates.

12. RELEASE REQUIRED FOR SEVERANCE PAYMENTS

Notwithstanding anything to the contrary in this Agreement, as a condition precedent to the receipt of any payment under Section 6, Section 7, or Section 9 of this Agreement pursuant to Executive's termination of employment with the Company, Executive shall be required to execute a general waiver and release agreement, in form drafted by and satisfactory to the Company, providing for the complete waiver, release, and discharge of all known and unknown present and future claims against the Company.

13. SECTION 280G

(a) SHAREHOLDER APPROVAL REQUIRED.

Notwithstanding anything to the contrary in this Agreement, Section 13 of this Agreement shall not become effective in any part unless and until it is fully disclosed to and approved by a vote of the persons who own more than seventy five percent (75%) of the voting power of all outstanding capital stock of the Company.

(b) GROSS-UP.

(i) Gross-Up Payment. If, notwithstanding clause (a) above, it is determined (pursuant to Section 13(b)(ii)) or finally determined (as defined in Section 13(b)(iii)) that any payment, distribution, transfer, or benefit by the Company or a direct or indirect subsidiary or affiliate of the Company, to or for the benefit of Executive or Executive's dependents, heirs or beneficiaries (whether such payment, distribution, transfer, benefit or other event occurs pursuant to the terms of this Agreement or otherwise, but determined without regard to any additional payments required under this Section 13(b)) (each a "Payment" and collectively the "Payments") is subject to the excise tax imposed by Section 4999 of the Code, and any successor provision or any comparable provision of state or local income tax law (collectively, "Section 4999"), or any interest, penalty or addition to tax is incurred by Executive with respect to such excise tax (such excise tax, together with any such interest, penalty, and addition to tax, hereinafter collectively referred to as the "Excise Tax"), then, within ten (10) days after such determination or final determination, as the case may be, the Company shall pay to Executive (or to the applicable taxing authority on Executive's behalf) an additional cash payment (hereinafter referred to as the "Gross-Up Payment") equal to an amount such that after payment by Executive of all taxes, interest, penalties, additions to tax and costs imposed or incurred with respect to the Gross-Up Payment (including, without limitation, any income and excise taxes imposed upon the Gross-Up Payment), Executive retains an amount of the Gross-Up Payment equal to the Excise Tax imposed upon such Payment or Payments. This provision is intended to put Executive in the same position as Executive would have been had no Excise Tax been imposed upon or incurred as a result of any Payment.

(ii) Determination of Gross-Up.

(A) Except as provided in Section 13(b)(iii), the determination that a Payment is subject to an Excise Tax shall be made in writing by the principal certified public accounting firm then retained by the Company to audit its annual financial statements (the "Accounting Firm"). Such determination shall include the amount of the Gross-Up Payment and detailed computations thereof, including any assumptions used in such computations. Any determination by the Accounting Firm will be binding on the Company and Executive.

(B) For purposes of determining the amount of the Gross-Up Payment, Executive shall be deemed to pay Federal income taxes at the highest marginal rate of Federal income taxation in the calendar year in which the Gross-Up Payment is to be made. Such highest marginal rate shall take into account the loss of itemized deductions by Executive and shall also include Executive's share of the hospital insurance portion of FICA and state and local income taxes at the highest marginal rate of taxation in the state and locality of Executive's residence on the date of his or her Qualifying Termination Event, net of the maximum reduction in Federal income taxes that could be obtained from the deduction of such state and local taxes.

(iii) Notification.

(A) Executive shall notify the Company in writing of any claim by the Internal Revenue Service (or any successor thereof) or any state or local taxing authority (individually or collectively, the "Taxing Authority") that, if successful, would require the payment by the Company of a Gross-Up Payment. Such notification shall be given as soon as practicable but no later than thirty (30) days after Executive receives written notice of such claim and shall apprise the Company of the nature of such claim and the date on which such claim is requested to be paid; provided, however, that failure by Executive to give such notice within such thirty (30) day period shall not result in a waiver or forfeiture of any of Executive's rights under this Section 13(b) except to the extent of actual damages suffered by the Company as a result of such failure. Executive shall not pay such claim prior to the expiration of the fifteen (15) day period following the date on which Executive gives such notice to the Company (or such shorter period ending on the date that any payment of taxes, interest, penalties or additions to tax with respect to such claim is due). If the Company notifies Executive in writing prior to the expiration of such fifteen (15) day period (regardless of whether such claim was earlier paid as contemplated by the preceding parenthetical) that it desires to contest such claim, Executive shall:

(1) give the Company any information reasonably requested by the Company relating to such claim;

(2) take such action in connection with contesting such claim as the Company shall reasonably request in writing from time to time, including, without limitation, accepting legal representation with respect to such claim by an attorney selected by the Company;

(3) cooperate with the Company in good faith in order effectively to contest such claim; and

(4) permit the Company to participate in any proceedings relating to such claim;

provided, however, that the Company shall bear and pay directly all attorneys fees, costs and expenses (including additional interest, penalties and additions to tax) incurred in connection with such contest and shall indemnify and hold Executive harmless, on an after-tax basis, for all taxes (including, without limitation, income and excise taxes), interest, penalties and additions to tax imposed in relation to such claim and in relation to the payment of such costs and expenses or indemnification.

(B) Without limitation on the foregoing provisions of this Section 13(b)(iii), and to the extent its actions do not unreasonably interfere with or prejudice Executive's disputes with the Taxing Authority as to other issues, the Company shall control all proceedings taken in connection with such contest and, in its or their reasonable discretion, may pursue or forego any and all administrative appeals, proceedings, hearings and conferences with the Taxing Authority in respect of such claim and may, at its or in their sole option, either direct Executive to pay the tax, interest or penalties claimed and sue for a refund or contest the claim in any permissible manner, and Executive agrees to prosecute such contest to a determination before any administrative tribunal, in a court of initial jurisdiction and in one or more appellate courts, as the Company shall determine; provided, however, that if the Company directs Executive to pay such claim and sue for a refund, the Company shall advance an amount equal to such payment to Executive, on an interest-free basis, and shall indemnify and hold Executive harmless, on an after-tax basis, from all taxes (including, without limitation, income and excise taxes), interest, penalties and additions to tax imposed with respect to such advance or with respect to any imputed income with respect to such advance, as any such amounts are incurred; and, further, provided, that any extension of the statute of limitations relating to payment of taxes, interest, penalties or additions to tax for the taxable year of Executive with respect to which such contested amount is claimed to be due is limited solely to such contested amount; and, provided, further, that any settlement of any claim shall be reasonably acceptable to Executive, and the Company's control of the contest shall be limited to issues with respect to which a Gross-Up Payment would be payable hereunder, and Executive shall be entitled to settle or contest, as the case may be, any other issue.

(C) If, after receipt by Executive of an amount advanced by the Company pursuant to Section 13(b)(iii)(A), Executive receives any refund with respect to such claim, Executive shall (subject to the Company's complying with the requirements of this Section 13(b)) promptly pay to the Company an amount equal to such refund (together with any interest paid or credited thereof after taxes applicable thereto), net of any taxes (including, without limitation, any income or excise taxes), interest, penalties or additions to tax and any other costs incurred by Executive in connection with such advance, after giving effect to such repayment. If, after the receipt by Executive of an amount advanced by the Company pursuant to Section 13(b)(iii)(A), it is finally determined that Executive is not entitled to any refund with respect to such claim, then such advance shall be forgiven and shall not be required to be repaid and the amount of such advance shall be treated as a Gross-Up Payment and shall offset, to the extent thereof, the amount of any Gross-Up Payment otherwise required to be paid.

(D) For purposes of this Section 13(b), whether the Excise Tax is applicable to a Payment shall be deemed to be "finally determined" upon the earliest of: (1) the expiration of the fifteen (15) day period referred to in Section 13(b)(iii)(A) if the Company or Executive's Company has not notified Executive that it intends to contest the underlying claim, (2) the expiration of any period following which no right of appeal exists, (3) the date upon which a closing agreement or similar agreement with respect to the claim is executed by Executive and the Taxing Authority (which agreement may be executed only in compliance with this section), or (4) the receipt by Executive of notice from the Company that it no longer seeks to pursue a contest (which shall be deemed received if the Company does not, within fifteen (15) days following receipt of a written inquiry from Executive, affirmatively indicate in writing to Executive that the Company intends to continue to pursue such contest).

It is possible that no Gross-Up Payment will initially be made but that a Gross-Up Payment should have been made, or that a Gross-Up Payment will initially be made in an amount that is less than what should have been made (either of such events is referred to as an "Underpayment"). It is also possible that a Gross-Up Payment will initially be made in an amount that is greater than what should have been made (an "Overpayment"). The determination of any Underpayment or Overpayment shall be made by the Accounting Firm in accordance with Section 13(b)(ii). In the event of an Underpayment, the amount of any such Underpayment shall be paid to Executive as an additional Gross-Up Payment. In the event of an Overpayment, any such Overpayment shall be treated for all purposes as a loan to Executive with interest at the applicable Federal rate provided for in Section 1274(d) of the Code. In such case, the amount of the loan shall be subject to reduction to the extent necessary to put Executive in the same after-tax position as if such Overpayment were never made. The amount of any such reduction to the loan shall be determined by the Accounting Firm in accordance with the principles set forth in Section 13(b)(ii). Executive shall repay the amount of the loan (after reduction, if any) to the Company as soon as administratively practicable after the Company notifies Executive of (x) the Accounting Firm's determination that an Overpayment was made and (y) the amount to be repaid.

14. CONTRACT REIMBURSEMENT

The Company shall reimburse Executive on a fully grossed-up, after-tax basis or directly pay for all reasonable legal fees and costs attributed to the development, reviews and modifications of this Agreement and associated legal services. Such fees and costs shall not exceed two thousand five hundred dollars ($2,500). This Section 14 shall not be deemed to limit any of Executive's rights under Section 23 ("Attorneys' Fees").

15. ASSIGNMENT

This Agreement is personal in its nature and neither of the parties hereto shall, without the consent of the other, assign or transfer this Agreement or any rights or obligations hereunder; provided, however, that, in the event of a merger, consolidation, or transfer or sale of all or substantially all of the assets of the Company with or to any other individual(s) or entity, this Agreement shall, subject to the provisions hereof, be binding upon and inure to the benefit of such successor and such successor shall discharge and perform all the promises, covenants, duties, and obligations of the Company hereunder.

16. GOVERNING LAW

This Agreement and the legal relations hereby created between the parties hereto shall be governed by and construed under and in accordance with the internal laws of the State of California, without regard to conflicts of laws principles thereof.

17. ENTIRE AGREEMENT

This Agreement embodies the entire agreement of the parties hereto respecting the matters within its scope. This Agreement supersedes all prior agreements of the parties hereto on the subject matter hereof. Any prior negotiations, correspondence, agreements, proposals, or understandings relating to the subject matter hereof shall be deemed to be merged into this Agreement and to the extent inconsistent herewith, such negotiations, correspondence, agreements, proposals, or understandings shall be deemed to be of no force or effect. There are no representations, warranties, or agreements, whether express or implied, or oral or written, with respect to the subject matter hereof, except as set forth herein.

18. MODIFICATIONS

This Agreement shall not be modified by any oral agreement, either express or implied, and all modifications hereof shall be in writing and signed by the parties hereto.

19. WAIVER

Failure to insist upon strict compliance with any of the terms, covenants, or conditions hereof shall not be deemed a waiver of such term, covenant, or condition, nor shall any waiver or relinquishment of, or failure to insist upon strict compliance with, any right or power hereunder at any one or more times be deemed a waiver or relinquishment of such right or power at any other time or times.

20. NUMBER AND GENDER

Where the context requires, the singular shall include the plural, the plural shall include the singular, and any gender shall include all other genders.

21. SECTION HEADINGS

The section headings in this Agreement are for the purpose of convenience only and shall not limit or otherwise affect any of the terms hereof.

22. ARBITRATION

Any controversy arising out of or relating to Executive's employment, this Agreement, its enforcement or interpretation, or because of an alleged breach, default, or misrepresentation in connection with any of its provisions, shall be submitted to arbitration in Los Angeles County, California, before a sole arbitrator who is either (a) a member of the National Academy of Arbitrators located in the State of California or (b) a retired California Superior Court or Appellate Court judge, and shall be conducted in accordance with the provisions of California Civil Procedure Code Sections 1280 et seq. as the exclusive remedy of such dispute; provided, however, that provisional injunctive relief may, but need not, be sought in a court of law while arbitration proceedings are pending, and any provisional injunctive relief granted by such court shall remain effective until the matter is finally determined by the Arbitrator. Final resolution of any dispute through arbitration may include any remedy or relief which the Arbitrator deems just and equitable. Any award or relief granted by the Arbitrator hereunder shall be final and binding on the parties hereto and may be enforced by any court of competent jurisdiction. The parties acknowledge and agree that they are hereby waiving any rights to trial by jury in any action, proceeding or counterclaim brought by either of the parties against the other in connection with any matter whatsoever arising out of or in any way connected with this Agreement or Executive's employment.

23. ATTORNEYS' FEES

Executive and the Company agree that in any dispute resolution proceedings arising out of this Agreement, the prevailing party shall be entitled to its or his reasonable attorneys' fees and costs incurred by it or him in connection with resolution of the dispute in addition to any other relief granted.

24. SEVERABILITY

In the event that a court of competent jurisdiction determines that any portion of this Agreement is in violation of any statute or public policy, then only the portions of this Agreement which violate such statute or public policy shall be stricken, and all portions of this Agreement which do not violate any statute or public policy shall continue in full force and effect. Furthermore, any court order striking any portion of this Agreement shall modify the stricken terms as narrowly as possible to give as much effect as possible to the intentions of the parties under this Agreement.

25. NOTICES

All notices under this Agreement shall be in writing and shall be either personally delivered or mailed postage prepaid, by certified mail, return receipt requested:

(a) if to the Company:

Molina Healthcare, Inc.
Attention:
One Golden Shore Drive
Long Beach, California 90802

(b) if to Executive:

Joseph M. Molina, MD
829 Stratford Avenue
South Pasadena, CA 91030

Notice shall be effective when personally delivered, or five (5) business days after being so mailed, or when transmitted via facsimile with confirmation of receipt.

26. COUNTERPARTS

This Agreement may be executed in any number of counterparts, each of which shall be deemed an original and all of which together shall constitute one and the same instrument.

27. WITHHOLDING TAXES

The Company may withhold from any amounts payable under this Agreement such federal, state and local taxes as may be required to be withheld pursuant to any applicable law or regulation.

IN WITNESS WHEREOF, the Company and Executive have executed this Employment Agreement as of the date first above written.

"COMPANY"
Molina Healthcare, Inc.

By: /s/ Janet Riedman

"EXECUTIVE"
Joseph M. Molina, MD

/s/

Joseph M. Molina, MD

ADDENDUM JOSEPH M MOLINA, MD AGREEMENT

RECITALS

Section 3 of the Agreement sets forth certain aspects of Executive's compensation. The Company and Executive desire to specify additional terms and conditions of Executive's compensation in this Addendum ("Addendum"), provided that this Addendum, and each of the terms and conditions set forth herein, shall be considered to be fully integrated into and a part of Section 3 of the Agreement.

AGREEMENT

The parties agree as follows:

1. Executive's Annual Bonus shall be equal to the lesser of:

   A. the product of (1 %) and (the EBITDA of the Company and its subsidiaries as determined on a consolidated basis by the Company's regular annual audit for such year) ("EBITDA"); or

   B. $500,000

provided that in no event shall such Annual Bonus be less than $0.

2. Executive's Annual Bonus shall be paid in quarterly estimates, as follows:

   A. Within a reasonable time after the Company's financial results for the first quarter of its fiscal year become available, Executive shall receive an amount equal to eighty percent (80%) of the lesser of: (i) the product of (1 %) and (EBITDA for such quarter) and (ii) $125,000 (the "First Quarter Payment"), provided that in no event shall such First Quarter Payment be less than $0.

   B. Within a reasonable time after the Company's financial results for the second quarter of its fiscal year become available, Executive shall receive an amount equal to eighty percent (80%) of the lesser of: (i) the difference between (a) the product of (1 %) and (EBITDA for the first two quarters) and (b) the First Quarter Payment, and (ii) $125,000 (the "Second Quarter Payment"), provided that in no event shall such Second Quarter Payment be less than $0.

   C. Within a reasonable time after the Company's financial results for the third quarter of its fiscal year become available, Executive shall receive an amount equal to the lesser of: (i) the difference between (a) the product of (1 %) and (EBITDA for the first three quarters) and (b) the sum of the First Quarter Payment and the Second Quarter Payment (the "Q2 Sum"), and (ii) the difference between $500,000 and the Q2 Sum (the "Third Quarter Payment"), provided that in no event shall such Third Quarter Payment be less than $0.

D. Prior to the end of the Company's fiscal year, Executive shall receive an amount equal to the lesser of: (i) the difference between (a) the product of (1 %) and (projected EBITDA, as estimated in good faith on a date reasonably close to the date of the Fourth Quarter Payment (as defined below) by the Compensation Committee of the Company's Board of Directors, for the Company's fiscal year) and (b) the sum of the First Quarter Payment, the Second Quarter Payment, and the Third Quarter Payment (the "Q3 Sum"); and (ii) the difference between $500,000 and the Q3 Sum (the "Fourth Quarter Payment" and, together with the First Quarter Payment, the Second Quarter Payment, and the Third Quarter Payment, the "Estimation Payments"), provided that in no event shall such Fourth Quarter Payment be less than $0.

E. The difference between the Annual Bonus and the sum of the Estimation Payments shall be paid by the Company to Executive, or repaid by Executive to the Company, as the case may be, in cash within thirty (30) days of the date on which Executive receives notice (as provided in Section 25 of the Agreement) of the amount of the Annual Bonus.

Executed and agreed to:

"COMPANY"
Molina Healthcare, Inc.

By: /s/ Janet Riedman

Name:
Title: Chairman of Compensation

"EXECUTIVE"
Joseph M. Molina, MD

/s/
- ------------------------
Joseph M. Molina, MD

EXHIBIT 10.8

EMPLOYMENT AGREEMENT

This Employment Agreement (this "Agreement") is made as of January 1,2002, between John C. Molina ("Executive") and Molina Healthcare, Inc. (the "Company").

RECITALS

The Company desires to establish its right to the services of Executive in the capacities described below, on the terms and conditions hereinafter set forth, and Executive is willing to accept such employment on such terms and conditions. The parties hereto have previously entered into an Employment Agreement dated May 1, 1997 (the "Existing Agreement"), and this Agreement supercedes the Existing Agreement.

AGREEMENT

The parties agree as follows:

1. DUTIES

(a) The Company does hereby hire, engage, and employ Executive as Executive Vice President of the Company, and Executive does hereby accept and agree to such hiring, engagement, and employment. During the Period of Employment (as defined in Section 2), Executive shall serve the Company in such position in conformity with the provisions of this Agreement, directives of the Chief Executive Officer and the corporate policies of the Company as they presently exist, and as such policies may be amended, modified, changed, or adopted during the Period of Employment. Executive shall have duties and authority consistent with Executive's position as Executive Vice President and shall report to the Chief Executive Officer of the Company (the "Reporting Relationship").

(b) Throughout the Period of Employment, Executive shall devote his time, energy, and skill to the performance of his duties for the Company, vacations and other leave authorized under this Agreement excepted. Notwithstanding the foregoing, Executive shall be permitted to (i) engage in charitable and community affairs and (ii) make direct investments of any character in any non-competing business or businesses and to manage such investments (but not be involved in the day-to-day operations of any such business); provided, in each case, and in the aggregate, that such activities do not materially interfere with the performance of Executive's duties hereunder, and further provided that Executive may invest in a publicly traded competing business so long as such investment does not equal or exceed one percent of the outstanding shares of such publicly traded competing business.

(c) Executive hereby represents to the Company that the execution and delivery of this Agreement by Executive and the Company and the performance by Executive of Executive's duties hereunder shall not constitute a breach of, or otherwise contravene, the terms of any employment or other agreement or policy to which Executive is a party or otherwise bound.

2. PERIOD OF EMPLOYMENT

The "Period of Employment" shall, unless sooner terminated as provided herein, be a period commencing on January 1, 2002 (the "Effective Date") and ending with the close of business on December 31, 2003. Notwithstanding the preceding sentence, commencing with January 1, 2003 and on each January 1st thereafter (each an "Extension Date"), the Period of Employment shall be automatically extended for an additional one-year period so as to expire one year from such Extension Date, unless: (i) the Company or Executive provides the other party hereto ninety (90) days' prior written notice before the next scheduled Extension Date that the Period of Employment shall not be so extended (the "Non-Extension Notice"); or (ii) Executive is not less than sixty-five (65) years of age as of the next scheduled Extension Date. The term "Period of Employment" shall include any extension that becomes applicable pursuant to the preceding sentence.

3. COMPENSATION

(a) BASE SALARY. Executive's Base Salary shall be at a rate of not less than $400,000 annually ("Executive's Base Salary"), paid in accordance with regular payroll practices, but not less than monthly. The Compensation Committee shall review at least annually Executive's Base Salary for possible increase in accordance with the Company's customary review practices for its senior executives and may, in his sole discretion, periodically adjust Executive's Base Salary to reflect individual performance. In the event of an increase, Executive's Base Salary for the year in which the increase occurs shall be adjusted on a pro rata basis to reflect the increase.

(b) BONUS. Executive shall be eligible to earn an annual discretionary bonus for each fiscal year of the Company (an "Annual Bonus"), with a target Annual Bonus (the "Target Bonus") of fifty percent (50%) of his Base Salary, to be awarded at the discretion of the Compensation Committee based on the achievement of certain mutually agreed upon objectives. Executive shall be entitled to participate in all bonus or incentive plans applicable to the senior executives of the Company, including without limitation any Effective Option Plan (as defined in Section 4(e)). CEO may in his sole discretion, also award to Executive such extraordinary bonus(es) as CEO deems appropriate.

4. BENEFITS

(a) HEALTH AND WELFARE. During the Period of Employment, Executive shall be entitled to participate, on the same terms and at the same level as other executives, in all health and welfare benefit plans and programs generally available to other executives or employees of the Company (including, without limitation, the Company's medical, dental, vision, life benefits, life insurance, and long-term disability plans) as in effect from time to time and to receive any special benefits provided from time to time, subject to any legally required restrictions specified in such plans and programs. Without limiting the generality of the foregoing, Company shall provide life insurance for Executive, with Executive to designate the beneficiary thereunder, in an amount equal to Executive's base salary as in effect on the date of this Agreement and as in effect on the first business day of each calendar year thereafter.

(b) PAID TIME OFF AND OTHER LEAVE. During the Period of Employment, Executive shall receive10.77 hours of paid time off per "pay period" of the Company (the "PTO"), subject to the Company's policies concerning accrual of PTO and provided that for any three hundred sixty five (365) day period within the Period of Employment Executive shall earn no less than a total of thirty five (35) days of PTO. Executive shall also be entitled to all other holiday and leave pay generally available to other executives of the Company.

(c) TRAVEL AND EXPENSE REIMBURSEMENTS. During the Period of Employment, Company will reimburse Executive for all reasonable expenses incurred in connection with performance of his duties under section 1 of this Agreement in accordance with the Company's expense reimbursement policies.

(d) RETIREMENT. During the Period of Employment, Executive shall be eligible to participate on the same terms and at the same level as other executives, in all retirement, 401(k), deferred compensation, or other savings plans generally available to other executives, or employees of the Company as in effect from time to time, subject to any legally required restrictions specified in such plans and programs

(e) EQUITY GRANTS.

(i) Existing Options. Executive holds on the Effective Date options for zero 0 shares of common stock of the Company (the "Existing Options") pursuant to an agreement entitled N/A, dated N/A. The Existing Options are subject to the terms and conditions of the Omnibus Stock and Incentive Plan (the "Option Plan"), and shall hereafter continue to be subject to and controlled by the terms and conditions of the Option Plan.

(ii) Initial Options. Executive shall, on the Effective Date, be granted stock options for zero (0) shares of the common stock of the Company (the "Initial Options") pursuant to an option agreement. The exercise price of the Initial Options will be $180 per share. The Initial Options are subject to the terms and conditions of the "Molina Healthcare, Inc. Amended and Restated Stock Incentive Plan" (the "Restated Option Plan").

(iii) Future Options. Executive shall be eligible, at the sole discretion of the Board, for additional annual stock option grants (the "Future Options") pursuant to one or more additional option agreements. Any Future Options will be granted under and subject to the terms and conditions of a stock option plan of the Company as then in effect (as of the date of any grant, an "Effective Option Plan"). The terms and conditions of such Future Options are intended to be such that Executive shall receive a compensation package commensurate with executives performing the same functions as Executives for businesses similar to the Company.

(f) OTHER BENEFITS. In addition to benefits specifically provided herein, during the Period of Employment, Executive shall be entitled to participate, on the same terms and at the same level as other executives, in all fringe benefit plans and perquisites provided by Company to its executives.

The employee benefits described in Sections 4(a) through (f) inclusive are referred to as "Executive Benefits."

5. DEATH OR DISABILITY

(a) PERMANENTLY DISABLED AND PERMANENT DISABILITY. The terms "Permanently Disabled" and "Permanent Disability" shall mean Executive's inability, because of physical or mental illness or injury, to perform the essential functions of his customary duties pursuant to this Agreement, with or without reasonable accommodation, and the continuation of such disabled condition for a period of twelve (12) months.

(b) TERMINATION DUE TO DEATH OR DISABILITY. If Executive dies or becomes Permanently Disabled during the Period of Employment, the Period of Employment and Executive's employment shall automatically cease and terminate as of the date of Executive's death or the date of Permanent Disability as determined by the Board (which date shall be referred to as the "Disability Date"), as the case may be. In the event of the termination of the Period of Employment and Executive's employment hereunder due to Executive's death or Permanent Disability, Executive or his estate shall be entitled to receive:

(i) Within five (5) business days, a lump sum cash payment equal to the sum of (x) any accrued but unpaid Base Salary and PTO as of the Termination Date hereunder and (y) any unpaid annual incentive compensation in respect of the most recently completed fiscal year preceding the Termination Date (the "Unpaid Annual Bonus"); and

(ii) Within thirty (30) days, such employee benefits described in Sections 4(a) and 4(c) through 4(f) inclusive, if any, as to which Executive may be entitled as of the Termination Date under the employee benefit plans and arrangements of the Company ((i) and (ii) collectively, the "Accrued Obligations").

6. TERMINATION BY THE COMPANY

(a) TERMINATION FOR CAUSE. The Company may terminate for Cause (as defined below) at any time the Period of Employment and Executive's employment hereunder by providing to Executive written notice of such termination ("Notice of Termination for Cause"). The term "Cause" shall mean a termination of service based upon a finding by the Company, acting in good faith and based on its reasonable belief at the time, that Executive:

(i) has engaged in unlawful acts involving moral turpitude or gross negligence with respect to the Company;

(ii) has consistently and willfully failed to perform his duties or has intentionally breached any material provision of any agreement with the Company or an affiliated entity; provided, however, that such failure or breach shall not constitute Cause unless it is (A) not reasonably curable or (B) if reasonably curable, is not cured by the Executive within thirty (30) days notice from the Company;

If the Executive's employment is terminated for Cause, the termination shall take effect on the Termination Date (as defined below). In the event of termination of the Period of Employment and Executive's employment hereunder due to a termination by the Company for Cause, Executive shall be entitled to receive the Accrued Obligations. All of the Accrued Obligations shall be paid on the Termination Date except those benefits described in Sections 4(a) and 4(c) through (f) inclusive, which shall be paid within thirty (30) days of the Termination Date.

If the Company attempts to terminate Executive's employment pursuant to this Section 6(a) and it is ultimately determined that the Company lacked Cause, the provisions of Section 6(b) ("Termination by the Company-Termination Without Cause") shall apply as if the Company had provided Executive with Notice of Termination Without Cause (as defined below) on the date the Company actually provided Executive with Notice of Termination for Cause.

(b) TERMINATION WITHOUT CAUSE. The Company may, without cause or reason, terminate at any time the Period of Employment and Executive's employment hereunder by providing Executive written notice of such termination ("Notice of Termination Without Cause"). A Non-Extension Notice by the Company shall be considered a termination without Cause. If Executive's employment is terminated without Cause, the termination shall take effect on the Termination Date. In the event of the termination of Executive's employment hereunder due to a termination by the Company without Cause (other than due to Executive's death or Permanent Disability):

(i) Executive shall be entitled to receive: (1) an amount equal to 100% of the sum of (x) Executive's Base Salary then in effect as of the Termination Date and (y) the Target Bonus for the fiscal year in which Executive's employment is terminated (the "Severance Payment"); (2) a pro rata portion of the Target Bonus for the fiscal year in which Executive's employment is terminated, based on the number of entire months of such fiscal year that have elapsed through the date of Executive's termination of employment as a fraction of twelve (12) (the "Pro Rata Bonus"); (3) the Accrued Obligations; (4) the entirety of Executive's contributions and the Company's contributions to Executive's 401(k) plan account as if Executive were fully vested as of the Termination Date, and (5) all other benefits under the welfare benefit and retirement plans contemplated by Sections 4(a) and 4(d) (the "Selected Benefits") until the earlier of (A) Executive's receipt of benefits substantially similar in scope and nature from another employer or (B) one year and one-half year after the Termination Date.

(ii) Executive shall be entitled to one hundred percent vesting of all of the options (including, without limitation, Existing Options, Initial Options, and Future Options) to purchase common stock of the Company ("Common Stock") held by Executive as of the Termination Date (the "Options").

Executive shall have no duty to mitigate damages and none of the payments provided in this Section 6(b) shall be reduced by any amounts earned or received by Executive from a third party at any time.

7. TERMINATION BY EMPLOYEE

(a) TERMINATION WITHOUT GOOD REASON. Executive shall have the right to terminate the Period of Employment and Executive's employment hereunder at any time without Good Reason (as defined below) upon fifteen (15) days prior written notice of such termination to the Company. A Non-Extension Notice by Executive shall be considered a termination without Good Reason. Any such termination by Executive without Good Reason shall be treated for all purposes of this Agreement as a termination by the Company for Cause and the provisions of Section 6(a) shall apply, provided, however, that notwithstanding the foregoing, if Executive terminates the Period of Employment without Good Reason, Executive shall be allowed to exercise the Executive Put Option with respect to Executive Shares received pursuant to the exercise of Existing Options, subject to the terms and conditions generally applicable with respect to the Executive Put Option.

(b) TERMINATION WITH GOOD REASON. Executive may terminate the Period of Employment and resign from employment hereunder for "Good Reason." "Good Reason" shall mean (with or without regard to whether a Change in Control Event has occurred), without obtaining Executive's prior written consent thereto:

(i) a material and adverse change in Executive's position, duties, responsibilities, Reporting Relationship or status with the Company,

(ii) a change in Executive's office location to a point more than fifty (50) miles from Executive's current office,

(iii) the taking of any action by the Company to: (A) eliminate benefit plans applicable to Executive without providing substitutes which provide a substantially similar aggregate value of benefits, (B) materially reduce Executive's benefits thereunder or (C) substantially diminish the aggregate value to Executive of incentive awards or other fringe benefits, provided, however, that it shall not constitute Good Reason for the Company to, as part of an overall cost-reduction program, take any action described in (A) - (C) so long as such action is taken with respect to all senior executives and Executive is not disproportionately affected thereby,

(iv) any reduction in the Base Salary, provided, however, that it shall not constitute Good Reason for the Company to, as part of an overall cost-reduction program, reduce Executive's Base Salary so long as the base salaries of all other senior executives are simultaneously reduced by not less than the same percentage, or

(v) any breach of this Agreement by the Company or any successor thereto, including without limitation any failure by the Company to obtain the consent of any Successor Entity (as defined below) to the provisions contained in Section 9; provided, however, that none of the events described in clause (v) of this Section 7(b) shall constitute Good Reason unless Executive shall have notified the Company in writing describing the events which constitute Good Reason and then only if the Company shall have failed to cure such event within thirty (30) days after the Company's receipt of such written notice.

Any such termination by Executive for Good Reason shall be treated for all purposes of this Agreement as a termination by the Company without Cause and the provisions of Section 6(b) shall apply; provided, however, that if Executive attempts to resign for Good Reason pursuant to this Section 7(b) and it is ultimately determined that Good Reason did not exist, Executive shall be deemed to have resigned from employment without Good Reason and the provisions of Section 7(a) and, by reference therein, the provisions of Section 6(a), shall apply.

8. TERMINATION DATE

The term "Termination Date" shall mean (i) if Executive's employment is terminated by the Company for Cause, or by Executive for Good Reason, the effective date (pursuant to Section 25 ("Notices")) of written notice of such termination to Executive or to the Company, as the case may be; (ii) if Executive's employment is terminated by the Company other than for Cause or Disability, the date on which the Company notifies Executive of such termination; or (iii) if Executive's employment is terminated by reason of Death or Disability, the Disability Date.

9. CHANGE IN CONTROL

(a) Notwithstanding anything to the contrary in this Agreement, if a Change in Control Event (as defined below) of the Company occurs during the term of this Agreement, and if within two years following such Change in Control Event either (1) the Company terminates Executive's employment without Cause or (2) Executive terminates his employment for Good Reason:

(i) the Company shall pay to Executive an amount equal to the sum of (w) two times the Severance Payment, (x) the Pro Rata Bonus, (y) the Accrued Obligations and (z) the entirety of Executive's contributions and the Company's contributions to Executive's 401(k) plan account as if Executive were fully vested as of the Termination Date, such amount to be, or to commence to be, paid on the Termination Date either in a single lump sum or in regular installments as a continuation of Executive's salary according to the Company's customary payroll practices, as determined by the Executive in his sole discretion at the time of termination. This payment shall be in lieu of the payment otherwise payable under clause (i) of Section 6(b).

(ii) the Company shall continue to provide the Selected Benefits until the earlier of (x) Executive's receipt of benefits substantially similar in scope and nature from another employer or (y) three years after the Termination Date.

(iii) and, regardless of whether any of the Options have been assumed by any Successor Entity, the provisions of clauses (ii) and (iii) of Section 6(b) will apply.

(b) A "Change in Control Event" shall mean any of the following:

(i) Approval by the Board and by shareholders of the Company (or, if no shareholder approval is required, by the Board alone) of the dissolution or liquidation of the Company, other than in the context of a transaction that does not constitute a Change in Control Event under clause (ii) below;

(ii) Consummation of a merger, consolidation, or other reorganization, with or into, or the sale of all or substantially all of the Company's business and/or assets as an entirety to, one or more entities that are not Subsidiaries or other affiliates of the Company (a "Business Combination"), unless (1) as a result of the Business Combination, more than fifty percent (50%) of the outstanding voting power generally in the election of directors of the surviving or resulting entity or a parent thereof (the "Successor Entity") immediately after the reorganization is, or will be, owned, directly or indirectly, by holders of the Company's voting securities immediately before the Business Combination; and (2) no "person" (as such term is used in Sections 13(d) and 14(d) of the Exchange Act), excluding the Successor Entity or an Excluded Person, beneficially owns, directly or indirectly, more than fifty percent (50%) of the outstanding shares or the combined voting power of the outstanding voting securities of the Successor Entity, after giving effect to the Business Combination, except to the extent that such ownership existed prior to the Business Combination; or

(iii) Any "person" (as such term is used in Sections 13(d) and 14(d) of the Exchange Act) other than an Excluded Person: (a) becomes the beneficial owner (as defined in Rule 13d-3 under the Exchange Act), directly or indirectly, of securities of the Company representing more than fifty percent (50%) of the combined voting power of the Company's then outstanding securities entitled to then vote generally in the election of directors (the "Voting Power") of the Company (a "Majority Holder"), other than as a result of (1) an acquisition directly from the Company, (2) an acquisition by the Company, or (3) an acquisition by an entity pursuant to a transaction which is expressly excluded under clause (ii) above (an "Excluded Transaction"); or (b) provided that the beneficial owner of a majority of the Voting Power as of the Effective Date is no longer a Majority Holder, becomes the beneficial owner (as defined in Rule 13d-3 under the Exchange Act), directly or indirectly, of securities of the Company representing more than thirty percent (30%) of the Voting Power, other than as a result of an Excluded Transaction.

(iv) For the purposes of this Section 9(c):

(A) "Exchange Act" shall mean the Securities Exchange Act of 1934, as amended from time to time.

(B) "Excluded Person" shall mean (a) any person described in and satisfying the conditions of Rule 13d-1(b)(1) under the Exchange Act, (b) the Company, (c) an employee benefit plan (or related trust) sponsored or maintained by the Company or the Successor Entity, or (d) any person who is the beneficial owner (as defined in Rule 13d-3 under the Exchange Act) of more than [25%] of the Common Stock on the Effective Date (or an affiliate, successor, heir, descendant, or related party of or to such person).

(C) "Subsidiary" shall mean any corporation or other entity a majority of whose outstanding voting stock or voting power is beneficially owned, directly or indirectly, by the Company.

(c) Executive shall have no duty to mitigate damages and none of the payments provided in this Section 9 shall be reduced by any amounts earned or received by Executive from a third party at any time. Notwithstanding anything to the contrary in this Section 9, if, in connection with a Change in Control Event, Executive voluntarily enters a new written employment agreement with the Company or the Successor Entity, Executive may no longer rely upon the provisions of this Section 9.

10. CONFIDENTIALITY

Executive will not at any time (whether during or after his employment with the Company), unless compelled by lawful process, disclose or use for his own benefit or purposes or the benefit or purposes of any other person, firm, partnership, joint venture, association, corporation or other business organization, entity or enterprise other than the Company and any of its subsidiaries or affiliates, any trade secrets, or other confidential data or information relating to customers, development programs, costs, marketing, trading, investment, sales activities, promotion, credit and financial data, financing methods, or plans of the Company or of any subsidiary or affiliate of the Company; provided that the foregoing shall not apply to information which is not unique to the Company or which is generally known to the industry or the public other than as a result of Executive's breach of this covenant. Executive agrees that upon termination of his employment with the Company for any reason, he will return to the Company immediately all memoranda, books, papers, plans, information, letters and other data, and all copies thereof or therefrom, in any way relating to the business of the Company and its affiliates, except that he may retain personal notes, notebooks and diaries that do not contain confidential information of the type described in the preceding sentence. Executive further agrees that he will not retain or use for his account at any time any trade names, trademark or other proprietary business designation used or owned in connection with the business of the Company or its affiliates.

11. NON-SOLICITATION AND NON-DISPARAGEMENT

During the Period of Employment and for a period of eighteen (18) months thereafter, Executive will not, directly or indirectly: (a) solicit or attempt to solicit any employee of the Company to terminate his or her relationship with the Company in order to become an employee, consultant or independent contractor to or for any other person or business entity; (b) solicit customers, suppliers or clients of the Company to reduce or discontinue their business with the Company or to engage in business with any competing entity; (c) disparage the Company, its business, or its reputation; or (d) otherwise disrupt or interfere with business relationships (whether formed before or after the date of this Agreement) between the Company or any of its affiliates and customers, suppliers, partners, members or investors of the Company or its affiliates.

12. RELEASE REQUIRED FOR SEVERANCE PAYMENTS

Notwithstanding anything to the contrary in this Agreement, as a condition precedent to the receipt of any payment under Section 6, Section 7, or Section 9 of this Agreement pursuant to Executive's termination of employment with the Company, Executive shall be required to execute a general waiver and release agreement, in form drafted by and satisfactory to the Company, providing for the complete waiver, release, and discharge of all known and unknown present and future claims against the Company.

13. SECTION 280G

(a) SHAREHOLDER APPROVAL REQUIRED.

Notwithstanding anything to the contrary in this Agreement, Section 13 of this Agreement shall not become effective in any part unless and until it is fully disclosed to and approved by a vote of the persons who own more than seventy five percent (75%) of the voting power of all outstanding capital stock of the Company.

(b) GROSS-UP.

(i) Gross-Up Payment. If, notwithstanding clause (a) above, it is determined (pursuant to Section 13(b)(ii)) or finally determined (as defined in Section 13(b)(iii)) that any payment, distribution, transfer, or benefit by the Company or a direct or indirect subsidiary or affiliate of the Company, to or for the benefit of Executive or Executive's dependents, heirs or beneficiaries (whether such payment, distribution, transfer, benefit or other event occurs pursuant to the terms of this Agreement or otherwise, but determined without regard to any additional payments required under this Section 13(b)) (each a "Payment" and collectively the "Payments") is subject to the excise tax imposed by Section 4999 of the Code, and any successor provision or any comparable provision of state or local income tax law (collectively, "Section 4999"), or any interest, penalty or addition to tax is incurred by Executive with respect to such excise tax (such excise tax, together with any such interest, penalty, and addition to tax, hereinafter collectively referred to as the "Excise Tax"), then, within ten (10) days after such determination or final determination, as the case may be, the Company shall pay to Executive (or to the applicable taxing authority on Executive's behalf) an additional cash payment (hereinafter referred to as the "Gross-Up Payment") equal to an amount such that after payment by Executive of all taxes, interest, penalties, additions to tax and costs imposed or incurred with respect to the Gross-Up Payment (including, without limitation, any income and excise taxes imposed upon the Gross-Up Payment), Executive retains an amount of the Gross-Up Payment equal to the Excise Tax imposed upon such Payment or Payments. This provision is intended to put Executive in the same position as Executive would have been had no Excise Tax been imposed upon or incurred as a result of any Payment.

(ii) Determination of Gross-Up.

(A) Except as provided in Section 13(b)(iii), the determination that a Payment is subject to an Excise Tax shall be made in writing by the principal certified public accounting firm then retained by the Company to audit its annual financial statements (the "Accounting Firm"). Such determination shall include

the amount of the Gross-Up Payment and detailed computations thereof, including any assumptions used in such computations. Any determination by the Accounting Firm will be binding on the Company and Executive.

(B) For purposes of determining the amount of the Gross-Up Payment, Executive shall be deemed to pay Federal income taxes at the highest marginal rate of Federal income taxation in the calendar year in which the Gross-Up Payment is to be made. Such highest marginal rate shall take into account the loss of itemized deductions by Executive and shall also include Executive's share of the hospital insurance portion of FICA and state and local income taxes at the highest marginal rate of taxation in the state and locality of Executive's residence on the date of his or her Qualifying Termination Event, net of the maximum reduction in Federal income taxes that could be obtained from the deduction of such state and local taxes.

(iii) Notification.

(A) Executive shall notify the Company in writing of any claim by the Internal Revenue Service (or any successor thereof) or any state or local taxing authority (individually or collectively, the "Taxing Authority") that, if successful, would require the payment by the Company of a Gross-Up Payment. Such notification shall be given as soon as practicable but no later than thirty (30) days after Executive receives written notice of such claim and shall apprise the Company of the nature of such claim and the date on which such claim is requested to be paid; provided, however, that failure by Executive to give such notice within such thirty (30) day period shall not result in a waiver or forfeiture of any of Executive's rights under this Section 13(b) except to the extent of actual damages suffered by the Company as a result of such failure. Executive shall not pay such claim prior to the expiration of the fifteen (15) day period following the date on which Executive gives such notice to the Company (or such shorter period ending on the date that any payment of taxes, interest, penalties or additions to tax with respect to such claim is due). If the Company notifies Executive in writing prior to the expiration of such fifteen (15) day period (regardless of whether such claim was earlier paid as contemplated by the preceding parenthetical) that it desires to contest such claim, Executive shall:

(1) give the Company any information reasonably requested by the Company relating to such claim;

(2) take such action in connection with contesting such claim as the Company shall reasonably request in writing from time to time, including, without limitation, accepting legal representation with respect to such claim by an attorney selected by the Company;

(3) cooperate with the Company in good faith in order effectively to contest such claim; and

(4) permit the Company to participate in any proceedings relating to such claim;

provided, however, that the Company shall bear and pay directly all attorneys fees, costs and expenses (including additional interest, penalties and additions to tax) incurred in connection with such contest and shall indemnify and hold Executive harmless, on an after-tax basis, for all taxes (including, without limitation, income and excise taxes), interest, penalties and additions to tax imposed in relation to such claim and in relation to the payment of such costs and expenses or indemnification.

(B) Without limitation on the foregoing provisions of this Section 13(b)(iii), and to the extent its actions do not unreasonably interfere with or prejudice Executive's disputes with the Taxing Authority as to other issues, the Company shall control all proceedings taken in connection with such contest and, in its or their reasonable discretion, may pursue or forego any and all administrative appeals, proceedings, hearings and conferences with the Taxing Authority in respect of such claim and may, at its or in their sole option, either direct Executive to pay the tax, interest or penalties claimed and sue for a refund or contest the claim in any permissible manner, and Executive agrees to prosecute such contest to a determination before any administrative tribunal, in a court of initial jurisdiction and in one or more appellate courts, as the Company shall determine; provided, however, that if the Company directs Executive to pay such claim and sue for a refund, the Company shall advance an amount equal to such payment to Executive, on an interest-free basis, and shall indemnify and hold Executive harmless, on an after-tax basis, from all taxes (including, without limitation, income and excise taxes), interest, penalties and additions to tax imposed with respect to such advance or with respect to any imputed income with respect to such advance, as any such amounts are incurred; and, further, provided, that any extension of the statute of limitations relating to payment of taxes, interest, penalties or additions to tax for the taxable year of Executive with respect to which such contested amount is claimed to be due is limited solely to such contested amount; and, provided, further, that any settlement of any claim shall be reasonably acceptable to Executive, and the Company's control of the contest shall be limited to issues with respect to which a Gross-Up Payment would be payable hereunder, and Executive shall be entitled to settle or contest, as the case may be, any other issue.

(C) If, after receipt by Executive of an amount advanced by the Company pursuant to Section 13(b)(iii)(A), Executive receives any refund with respect to such claim, Executive shall (subject to the Company's complying with the requirements of this Section 13(b)) promptly pay to the Company an amount equal to such refund (together with any interest paid or credited thereof after taxes applicable thereto), net of any taxes (including, without limitation, any income or excise taxes), interest, penalties or additions to tax and any other costs incurred by Executive in connection with such advance, after giving effect to such repayment. If, after the receipt by Executive of an amount advanced by the Company

pursuant to Section 13(b)(iii)(A), it is finally determined that Executive is not entitled to any refund with respect to such claim, then such advance shall be forgiven and shall not be required to be repaid and the amount of such advance shall be treated as a Gross-Up Payment and shall offset, to the extent thereof, the amount of any Gross-Up Payment otherwise required to be paid.

(D) For purposes of this Section 13(b), whether the Excise Tax is applicable to a Payment shall be deemed to be "finally determined" upon the earliest of: (1) the expiration of the fifteen (15) day period referred to in Section 13(b)(iii)(A) if the Company or Executive's Company has not notified Executive that it intends to contest the underlying claim, (2) the expiration of any period following which no right of appeal exists, (3) the date upon which a closing agreement or similar agreement with respect to the claim is executed by Executive and the Taxing Authority (which agreement may be executed only in compliance with this section), or (4) the receipt by Executive of notice from the Company that it no longer seeks to pursue a contest (which shall be deemed received if the Company does not, within fifteen (15) days following receipt of a written inquiry from Executive, affirmatively indicate in writing to Executive that the Company intends to continue to pursue such contest).

It is possible that no Gross-Up Payment will initially be made but that a Gross-Up Payment should have been made, or that a Gross-Up Payment will initially be made in an amount that is less than what should have been made (either of such events is referred to as an "Underpayment"). It is also possible that a Gross-Up Payment will initially be made in an amount that is greater than what should have been made (an "Overpayment"). The determination of any Underpayment or Overpayment shall be made by the Accounting Firm in accordance with Section 13(b)(ii). In the event of an Underpayment, the amount of any such Underpayment shall be paid to Executive as an additional Gross-Up Payment. In the event of an Overpayment, any such Overpayment shall be treated for all purposes as a loan to Executive with interest at the applicable Federal rate provided for in Section 1274(d) of the Code. In such case, the amount of the loan shall be subject to reduction to the extent necessary to put Executive in the same after-tax position as if such Overpayment were never made. The amount of any such reduction to the loan shall be determined by the Accounting Firm in accordance with the principles set forth in Section 13(b)(ii). Executive shall repay the amount of the loan (after reduction, if any) to the Company as soon as administratively practicable after the Company notifies Executive of (x) the Accounting Firm's determination that an Overpayment was made and (y) the amount to be repaid.

14. CONTRACT REIMBURSEMENT

The Company shall reimburse Executive on a fully grossed-up, after-tax basis or directly pay for all reasonable legal fees and costs attributed to the development, reviews and modifications of this Agreement and associated legal services. Such fees and costs shall not exceed two thousand five hundred dollars ($2,500). This Section 14 shall not be deemed to limit any of Executive's rights under Section 23 ("Attorneys' Fees").

15. ASSIGNMENT

This Agreement is personal in its nature and neither of the parties hereto shall, without the consent of the other, assign or transfer this Agreement or any rights or obligations hereunder; provided, however, that, in the event of a merger, consolidation, or transfer or sale of all or substantially all of the assets of the Company with or to any other individual(s) or entity, this Agreement shall, subject to the provisions hereof, be binding upon and inure to the benefit of such successor and such successor shall discharge and perform all the promises, covenants, duties, and obligations of the Company hereunder.

16. GOVERNING LAW

This Agreement and the legal relations hereby created between the parties hereto shall be governed by and construed under and in accordance with the internal laws of the State of California, without regard to conflicts of laws principles thereof.

17. ENTIRE AGREEMENT

This Agreement embodies the entire agreement of the parties hereto respecting the matters within its scope. This Agreement supersedes all prior agreements of the parties hereto on the subject matter hereof. Any prior negotiations, correspondence, agreements, proposals, or understandings relating to the subject matter hereof shall be deemed to be merged into this Agreement and to the extent inconsistent herewith, such negotiations, correspondence, agreements, proposals, or understandings shall be deemed to be of no force or effect. There are no representations, warranties, or agreements, whether express or implied, or oral or written, with respect to the subject matter hereof, except as set forth herein.

18. MODIFICATIONS

This Agreement shall not be modified by any oral agreement, either express or implied, and all modifications hereof shall be in writing and signed by the parties hereto.

19. WAIVER

Failure to insist upon strict compliance with any of the terms, covenants, or conditions hereof shall not be deemed a waiver of such term, covenant, or condition, nor shall any waiver or relinquishment of, or failure to insist upon strict compliance with, any right or power hereunder at any one or more times be deemed a waiver or relinquishment of such right or power at any other time or times.

20. NUMBER AND GENDER

Where the context requires, the singular shall include the plural, the plural shall include the singular, and any gender shall include all other genders.

21. SECTION HEADINGS

The section headings in this Agreement are for the purpose of convenience only and shall not limit or otherwise affect any of the terms hereof.

22. ARBITRATION

Any controversy arising out of or relating to Executive's employment, this Agreement, its enforcement or interpretation, or because of an alleged breach, default, or misrepresentation in connection with any of its provisions, shall be submitted to arbitration in Los Angeles County, California, before a sole arbitrator who is either (a) a member of the National Academy of Arbitrators located in the State of California or (b) a retired California Superior Court or Appellate Court judge, and shall be conducted in accordance with the provisions of California Civil Procedure Code Sections 1280 et seq. as the exclusive remedy of such dispute; provided, however, that provisional injunctive relief may, but need not, be sought in a court of law while arbitration proceedings are pending, and any provisional injunctive relief granted by such court shall remain effective until the matter is finally determined by the Arbitrator. Final resolution of any dispute through arbitration may include any remedy or relief which the Arbitrator deems just and equitable. Any award or relief granted by the Arbitrator hereunder shall be final and binding on the parties hereto and may be enforced by any court of competent jurisdiction. The parties acknowledge and agree that they are hereby waiving any rights to trial by jury in any action, proceeding or counterclaim brought by either of the parties against the other in connection with any matter whatsoever arising out of or in any way connected with this Agreement or Executive's employment.

23. ATTORNEYS' FEES

Executive and the Company agree that in any dispute resolution proceedings arising out of this Agreement, the prevailing party shall be entitled to its or his reasonable attorneys' fees and costs incurred by it or him in connection with resolution of the dispute in addition to any other relief granted.

24. SEVERABILITY

In the event that a court of competent jurisdiction determines that any portion of this Agreement is in violation of any statute or public policy, then only the portions of this Agreement which violate such statute or public policy shall be stricken, and all portions of this Agreement which do not violate any statute or public policy shall continue in full force and effect. Furthermore, any court order striking any portion of this Agreement shall modify the stricken terms as narrowly as possible to give as much effect as possible to the intentions of the parties under this Agreement.

25. NOTICES

All notices under this Agreement shall be in writing and shall be either personally delivered or mailed postage prepaid, by certified mail, return receipt requested:

(a) if to the Company:

Molina Healthcare, Inc.
Attention: J. Mario Molina, M.D., President and Chief Executive Officer
One Golden Shore Drive
Long Beach, California 90802

(b) if to Executive:

John C. Molina
2625 East Ocean
Long Beach, CA 90803

Notice shall be effective when personally delivered, or five (5) business days after being so mailed, or when transmitted via facsimile with confirmation of receipt.

26. COUNTERPARTS

This Agreement may be executed in any number of counterparts, each of which shall be deemed an original and all of which together shall constitute one and the same instrument.

27. WITHHOLDING TAXES

The Company may withhold from any amounts payable under this Agreement such federal, state and local taxes as may be required to be withheld pursuant to any applicable law or regulation. IN WITNESS WHEREOF, the Company and Executive have executed this Employment Agreement as of the date first above written.

"COMPANY"
Molina Healthcare, Inc.

By: /s/

J. Mario Molina, M.D.
Chairman, President, and Chief
Executive Officer

"EXECUTIVE"
John C. Molina
/s/

John C. Molina

EXHIBIT 10.9

EMPLOYMENT AGREEMENT

This Employment Agreement (this "Agreement") is made as of December 1, 2001, between Mark L. Andrews ("Executive") and Molina Healthcare, Inc. (the "Company").

RECITALS

The Company desires to establish its right to the services of Executive in the capacities described below, on the terms and conditions hereinafter set forth, and Executive is willing to accept such employment on such terms and conditions. The parties hereto have previously entered into an Employment Agreement dated December 2, 1997 (the "Existing Agreement"), and this Agreement supercedes the Existing Agreement.

AGREEMENT

The parties agree as follows:

1. DUTIES

(a) The Company does hereby hire, engage, and employ Executive as Executive Vice President of the Company, and Executive does hereby accept and agree to such hiring, engagement, and employment. During the Period of Employment (as defined in Section 2), Executive shall serve the Company in such position in conformity with the provisions of this Agreement, directives of the Chief Executive Officer and the corporate policies of the Company as they presently exist, and as such policies may be amended, modified, changed, or adopted during the Period of Employment. Executive shall have duties and authority consistent with Executive's position as Executive Vice President and shall report to the Chief Executive Officer of the Company (the "Reporting Relationship").

(b) Throughout the Period of Employment, Executive shall devote his time, energy, and skill to the performance of his duties for the Company, vacations and other leave authorized under this Agreement excepted. Notwithstanding the foregoing, Executive shall be permitted to (i) engage in charitable and community affairs and (ii) make direct investments of any character in any non-competing business or businesses and to manage such investments (but not be involved in the day-to-day operations of any such business); provided, in each case, and in the aggregate, that such activities do not materially interfere with the performance of Executive's duties hereunder, and further provided that Executive may invest in a publicly traded competing business so long as such investment does not equal or exceed one percent of the outstanding shares of such publicly traded competing business.

(c) Executive hereby represents to the Company that the execution and delivery of this Agreement by Executive and the Company and the performance by Executive of Executive's duties hereunder shall not constitute a breach of, or otherwise contravene, the terms of any employment or other agreement or policy to which Executive is a party or otherwise bound.

2. PERIOD OF EMPLOYMENT

The "Period of Employment" shall, unless sooner terminated as provided herein, be a period commencing on December 1, 2001 (the "Effective Date") and ending with the close of business on December 1, 2004. Notwithstanding the preceding sentence, commencing with December 1, 2004 and on each December 1st thereafter (each an "Extension Date"), the Period of Employment shall be automatically extended for an additional one-year period so as to expire one year from such Extension Date, unless: (i) the Company or Executive provides the other party hereto ninety (90) days' prior written notice before the next scheduled Extension Date that the Period of Employment shall not be so extended (the "Non-Extension Notice"); or (ii) Executive is not less than sixty-five (65) years of age as of the next scheduled Extension Date. The term "Period of Employment" shall include any extension that becomes applicable pursuant to the preceding sentence.

3. COMPENSATION

(a) BASE SALARY. Executive's Base Salary shall be at a rate of not less than $323,400 annually ("Executive's Base Salary"), paid in accordance with regular payroll practices, but not less than monthly. The CEO shall review at least annually Executive's Base Salary for possible increase in accordance with the Company's customary review practices for its senior executives and may, in his sole discretion, periodically adjust Executive's Base Salary to reflect individual performance. In the event of an increase, Executive's Base Salary for the year in which the increase occurs shall be adjusted on a pro rata basis to reflect the increase.

(b) BONUS. Executive shall be eligible to earn an annual discretionary bonus for each fiscal year of the Company (an "Annual Bonus"), with a target Annual Bonus (the "Target Bonus") of forty percent (40%) of his Base Salary, to be awarded at the sole discretion of the CEO based on the achievement of certain mutually agreed upon objectives. Executive shall be entitled to participate in all bonus or incentive plans applicable to the senior executives of the Company, including without limitation any Effective Option Plan (as defined in Section 4(e)). CEO may in his sole discretion, also award to Executive such extraordinary bonus(es) as CEO deems appropriate.

4. BENEFITS

(a) HEALTH AND WELFARE. During the Period of Employment, Executive shall be entitled to participate, on the same terms and at the same level as other executives, in all health and welfare benefit plans and programs generally available to other executives or employees of the Company (including, without limitation, the Company's medical, dental, vision, life benefits, life insurance, and long-term disability plans) as in effect from time to time and to receive any special benefits provided from time to time, subject to any legally required restrictions specified in such plans and programs. Without limiting the generality of the foregoing, Company shall provide life insurance for Executive, with Executive to designate the beneficiary thereunder, in an amount equal to Executive's base salary as in effect on the date of this Agreement and as in effect on the first business day of each calendar year thereafter.

(b) PAID TIME OFF AND OTHER LEAVE. During the Period of Employment, Executive shall receive10.77 hours of paid time off per "pay period" of the Company (the "PTO"), subject to the Company's policies concerning accrual of PTO and provided that for any three hundred sixty five (365) day period within the Period of Employment Executive shall earn no less than a total of thirty five (35) days of PTO. Executive shall also be entitled to all other holiday and leave pay generally available to other executives of the Company.

(c) TRAVEL AND EXPENSE REIMBURSEMENTS. During the Period of Employment, Company will reimburse Executive for all reasonable expenses incurred in connection with performance of his duties under section 1 of this Agreement in accordance with the Company's expense reimbursement policies.

(d) RETIREMENT. During the Period of Employment, Executive shall be eligible to participate on the same terms and at the same level as other executives, in all retirement, 401(k), deferred compensation, or other savings plans generally available to other executives, or employees of the Company as in effect from time to time, subject to any legally required restrictions specified in such plans and programs.

(e) EQUITY GRANTS.

(i) Existing Options. Executive holds on the Effective Date options for five thousand (5,000) shares of common stock of the Company (the "Existing Options") pursuant to an agreement entitled Agreement Relating to Stock Options, dated December 13,1999, as amended. The Existing Options are subject to the terms and conditions of the Omnibus Stock and Incentive Plan (the "Option Plan"), and shall hereafter continue to be subject to and controlled by the terms and conditions of the Option Plan.

(ii) Initial Options. Executive shall, on the Effective Date, be granted stock options for one thousand eight hundred (1,800) shares of the common stock of the Company (the "Initial Options") pursuant to an option agreement. The exercise price of the Initial Options will be $180 per share. The Initial Options are subject to the terms and conditions of the Option Plan.

(iii) Future Options. Executive shall be eligible, at the sole discretion of the Board, for additional annual stock option grants (the "Future Options") pursuant to one or more additional option agreements. Any Future Options will be granted under and subject to the terms and conditions of a stock option plan of the Company as then in effect (as of the date of any grant, an "Effective Option Plan"). The terms and conditions of such Future Options are intended to be such that Executive shall receive a compensation package commensurate with executives performing the same functions as Executives for businesses similar to the Company.

(f) OTHER BENEFITS. In addition to benefits specifically provided herein, during the Period of Employment, Executive shall be entitled to participate, on the same terms and at the same level as other executives, in all fringe benefit plans and perquisites provided by Company to its executives.

The employee benefits described in Sections 4(a) through (f) inclusive are referred to as "Executive Benefits."

5. DEATH OR DISABILITY

(a) PERMANENTLY DISABLED AND PERMANENT DISABILITY. The terms "Permanently Disabled" and "Permanent Disability" shall mean Executive's inability, because of physical or mental illness or injury, to perform the essential functions of his customary duties pursuant to this Agreement, with or without reasonable accommodation, and the continuation of such disabled condition for a period of twelve (12) months.

(b) TERMINATION DUE TO DEATH OR DISABILITY. If Executive dies or becomes Permanently Disabled during the Period of Employment, the Period of Employment and Executive's employment shall automatically cease and terminate as of the date of Executive's death or the date of Permanent Disability as determined by the Board (which date shall be referred to as the "Disability Date"), as the case may be. In the event of the termination of the Period of Employment and Executive's employment hereunder due to Executive's death or Permanent Disability, Executive or his estate shall be entitled to receive:

(i) Within five (5) business days, a lump sum cash payment equal to the sum of (x) any accrued but unpaid Base Salary and PTO as of the Termination Date hereunder and (y) any unpaid annual incentive compensation in respect of the most recently completed fiscal year preceding the Termination Date (the "Unpaid Annual Bonus"); and

(ii) Within thirty (30) days, such employee benefits described in Sections 4(a) and 4(c) through 4(f) inclusive, if any, as to which Executive may be entitled as of the Termination Date under the employee benefit plans and arrangements of the Company ((i) and (ii) collectively, the "Accrued Obligations").

6. TERMINATION BY THE COMPANY

(a) TERMINATION FOR CAUSE. The Company may terminate for Cause (as defined below) at any time the Period of Employment and Executive's employment hereunder by providing to Executive written notice of such termination ("Notice of Termination for Cause"). The term "Cause" shall mean a termination of service based upon a finding by the Company, acting in good faith and based on its reasonable belief at the time, that Executive:

(i) has engaged in unlawful acts involving moral turpitude or gross negligence with respect to the Company;

(ii) has consistently and willfully failed to perform his duties or has intentionally breached any material provision of any agreement with the Company or an affiliated entity; provided, however, that such failure or breach shall not constitute Cause unless it is (A) not reasonably curable or (B) if reasonably curable, is not cured by the Executive within thirty (30) days notice from the Company;

If the Executive's employment is terminated for Cause, the termination shall take effect on the Termination Date (as defined below). In the event of termination of the Period of Employment and Executive's employment hereunder due to a termination by the Company for Cause, Executive shall be entitled to receive the Accrued Obligations. All of the Accrued Obligations shall be paid on the Termination Date except those benefits described in Sections 4(a) and 4(c) through (f) inclusive, which shall be paid within thirty (30) days of the Termination Date.

If the Company attempts to terminate Executive's employment pursuant to this Section 6(a) and it is ultimately determined that the Company lacked Cause, the provisions of Section 6(b) ("Termination by the Company-Termination Without Cause") shall apply as if the Company had provided Executive with Notice of Termination Without Cause (as defined below) on the date the Company actually provided Executive with Notice of Termination for Cause.

(b) TERMINATION WITHOUT CAUSE. The Company may, without cause or reason, terminate at any time the Period of Employment and Executive's employment hereunder by providing Executive written notice of such termination ("Notice of Termination Without Cause"). A Non-Extension Notice by the Company shall be considered a termination without Cause. If Executive's employment is terminated without Cause, the termination shall take effect on the Termination Date. In the event of the termination of Executive's employment hereunder due to a termination by the Company without Cause (other than due to Executive's death or Permanent Disability):

(i) Executive shall be entitled to receive: (1) an amount equal to 100% of the sum of (x) Executive's Base Salary then in effect as of the Termination Date and (y) the Target Bonus for the fiscal year in which Executive's employment is terminated (the "Severance Payment"); (2) a pro rata portion of the Target Bonus for the fiscal year in which Executive's employment is terminated, based on the number of entire months of such fiscal year that have elapsed through the date of Executive's termination of employment as a fraction of twelve (12) (the "Pro Rata Bonus"); (3) the Accrued Obligations; (4) the entirety of Executive's contributions and the Company's contributions to Executive's 401(k) plan account as if Executive were fully vested as of the Termination Date, and (5) all other benefits under the welfare benefit and retirement plans contemplated by Sections 4(a) and 4(d) (the "Selected Benefits") until the earlier of (A) Executive's receipt of benefits substantially similar in scope and nature from another employer or (B) one year and one-half year after the Termination Date.

(ii) Executive shall be entitled to one hundred percent vesting of all of the options (including, without limitation, Existing Options, Initial Options, and Future Options) to purchase common stock of the Company ("Common Stock") held by Executive as of the Termination Date (the "Options").

(iii) Company shall, upon the written request of Executive (the "Executive Put Option") be required to repurchase all shares of Common Stock acquired by Executive pursuant to the exercise of stock options granted to and/or held by Executive as of the Termination Date (the "Executive Shares"). Executive may not exercise the Executive Put Option with respect to Executive Shares within the six-month period following the

date Executive acquired such Executive Shares, and the Executive Put Option may not be exercised at any time after the Company becomes publicly traded. The repurchase price for each Executive Share shall be equal to the fair market value of a share of Common Stock ("Fair Market Value"), which Fair Market Value:

(A) shall be determined as of the date of the exercise of Executive Put Option by an independent appraiser chosen by the Company and Executive as follows: the Company shall identify three appraisers independent of the Company, and Executive shall select one from the three identified; and

(B) shall be determined without any minority, illiquidity or other discount.

(iv) Amounts payable under this Section 6(b) shall be payable as follows:

(A) amounts payable under clause (i) shall be, or shall commence to be, paid within 30 days following the Termination Date either in a single lump sum or in regular installments as a continuation of Executive's salary according to the Company's customary payroll practices, as determined by the Executive in his sole discretion; provided however that any amounts representing accrued but unpaid Executive Base Salary, PTO an Unpaid Annual Bonus shall be paid on the Termination Date.

(B) amounts payable under clause (iii) that are attributable to the exercise of Existing Options and/or Initial Options shall be paid by the Company in accordance with the terms and conditions of the Option Plan. Amounts payable under clause (iii) that are attributable to the exercise of Future Options shall be paid by the Company in three annual lump sum installments as follows: (1) within 30 days after the Termination Date, one-third of the payout; (2) on the first anniversary of the Termination Date, one-third of the payout, with interest on the previously unpaid portion of the payout accrued from the Termination Date at the applicable federal rate; and (3) on the second anniversary of the Termination Date, the remaining one-third of the payout, with interest on such previously unpaid portion of the payout accrued from the first anniversary of the Termination Date at the applicable federal rate.

Executive shall have no duty to mitigate damages and none of the payments provided in this Section 6(b) shall be reduced by any amounts earned or received by Executive from a third party at any time.

7. TERMINATION BY EMPLOYEE

(a) TERMINATION WITHOUT GOOD REASON. Executive shall have the right to terminate the Period of Employment and Executive's employment hereunder at any time without Good Reason (as defined below) upon fifteen (15) days prior written notice of such termination to the Company. A Non-Extension Notice by Executive shall be considered a termination without Good Reason. Any such termination by Executive without Good Reason shall be treated for all purposes of this Agreement as a termination by the Company for Cause

and the provisions of Section 6(a) shall apply, provided, however, that notwithstanding the foregoing, if Executive terminates the Period of Employment without Good Reason, Executive shall be allowed to exercise the Executive Put Option with respect to Executive Shares received pursuant to the exercise of Existing Options, subject to the terms and conditions generally applicable with respect to the Executive Put Option.

(b) TERMINATION WITH GOOD REASON. Executive may terminate the Period of Employment and resign from employment hereunder for "Good Reason." "Good Reason" shall mean (with or without regard to whether a Change in Control Event has occurred), without obtaining Executive's prior written consent thereto:

(i) a material and adverse change in Executive's position, duties, responsibilities, Reporting Relationship or status with the Company,

(ii) a change in Executive's office location to a point more than fifty (50) miles from Executive's current office,

(iii) the taking of any action by the Company to: (A) eliminate benefit plans applicable to Executive without providing substitutes which provide a substantially similar aggregate value of benefits, (B) materially reduce Executive's benefits thereunder or (C) substantially diminish the aggregate value to Executive of incentive awards or other fringe benefits, provided, however, that it shall not constitute Good Reason for the Company to, as part of an overall cost-reduction program, take any action described in (A) - (C) so long as such action is taken with respect to all senior executives and Executive is not disproportionately affected thereby,

(iv) any reduction in the Base Salary, provided, however, that it shall not constitute Good Reason for the Company to, as part of an overall cost-reduction program, reduce Executive's Base Salary so long as the base salaries of all other senior executives are simultaneously reduced by not less than the same percentage, or

(v) any breach of this Agreement by the Company or any successor thereto, including without limitation any failure by the Company to obtain the consent of any Successor Entity (as defined below) to the provisions contained in Section 9; provided, however, that none of the events described in clause (v) of this Section 7(b) shall constitute Good Reason unless Executive shall have notified the Company in writing describing the events which constitute Good Reason and then only if the Company shall have failed to cure such event within thirty (30) days after the Company's receipt of such written notice.

Any such termination by Executive for Good Reason shall be treated for all purposes of this Agreement as a termination by the Company without Cause and the provisions of Section 6(b) shall apply; provided, however, that if Executive attempts to resign for Good Reason pursuant to this Section 7(b) and it is ultimately determined that Good Reason did not exist, Executive shall be deemed to have resigned from employment without Good Reason and the provisions of Section 7(a) and, by reference therein, the provisions of Section 6(a), shall apply.

8. TERMINATION DATE

The term 'Termination Date" shall mean (i) if Executive's employment is terminated by the Company for Cause, or by Executive for Good Reason, the effective date (pursuant to Section 25 ("Notices")) of written notice of such termination to Executive or to the Company, as the case may be; (ii) if Executive's employment is terminated by the Company other than for Cause or Disability, the date on which the Company notifies Executive of such termination; or (iii) if Executive's employment is terminated by reason of Death or Disability, the Disability Date.

9. CHANGE IN CONTROL

(a) Notwithstanding anything to the contrary in this Agreement, if a Change in Control Event (as defined below) of the Company occurs during the term of this Agreement, and if within two years following such Change in Control Event either (1) the Company terminates Executive's employment without Cause or (2) Executive terminates his employment for Good Reason:

(i) the Company shall pay to Executive an amount equal to the sum of (w) two times the Severance Payment, (x) the Pro Rata Bonus, (y) the Accrued Obligations and (z) the entirety of Executive's contributions and the Company's contributions to Executive's 401(k) plan account as if Executive were fully vested as of the Termination Date, such amount to be, or to commence to be, paid on the Termination Date either in a single lump sum or in regular installments as a continuation of Executive's salary according to the Company's customary payroll practices, as determined by the Executive in his sole discretion at the time of termination. This payment shall be in lieu of the payment otherwise payable under clause (i) of Section 6(b).

(ii) the Company shall continue to provide the Selected Benefits until the earlier of (x) Executive's receipt of benefits substantially similar in scope and nature from another employer or (y) three years after the Termination Date.

(iii) and, regardless of whether any of the Options have been assumed by any Successor Entity, the provisions of clauses (ii) and (iii) of Section 6(b) will apply.

(b) A "Change in Control Event" shall mean any of the following:

(i) Approval by the Board and by shareholders of the Company (or, if no shareholder approval is required, by the Board alone) of the dissolution or liquidation of the Company, other than in the context of a transaction that does not constitute a Change in Control Event under clause (ii) below;

(ii) Consummation of a merger, consolidation, or other reorganization, with or into, or the sale of all or substantially all of the Company's business and/or assets as an entirety to, one or more entities that are not Subsidiaries or other affiliates of the Company (a "Business Combination"), unless (1) as a result of the Business Combination, more than fifty percent (50%) of the outstanding voting power generally in the election of directors of the surviving or resulting entity or a parent thereof (the "Successor Entity") immediately after the reorganization

is, or will be, owned, directly or indirectly, by holders of the Company's voting securities immediately before the Business Combination; and (2) no "person" (as such term is used in Sections 13(d) and 14(d) of the Exchange Act), excluding the Successor Entity or an Excluded Person, beneficially owns, directly or indirectly, more than fifty percent (50%) of the outstanding shares or the combined voting power of the outstanding voting securities of the Successor Entity, after giving effect to the Business Combination, except to the extent that such ownership existed prior to the Business Combination; or

(iii) Any "person" (as such term is used in Sections 13(d) and 14(d) of the Exchange Act) other than an Excluded Person: (a) becomes the beneficial owner (as defined in Rule 13d-3 under the Exchange Act), directly or indirectly, of securities of the Company representing more than fifty percent (50%) of the combined voting power of the Company's then outstanding securities entitled to then vote generally in the election of directors (the "Voting Power") of the Company (a "Majority Holder"), other than as a result of (1) an acquisition directly from the Company, (2) an acquisition by the Company, or (3) an acquisition by an entity pursuant to a transaction which is expressly excluded under clause (ii) above (an "Excluded Transaction"); or (b) provided that the beneficial owner of a majority of the Voting Power as of the Effective Date is no longer a Majority Holder, becomes the beneficial owner (as defined in Rule 13d-3 under the Exchange Act), directly or indirectly, of securities of the Company representing more than thirty percent (30%) of the Voting Power, other than as a result of an Excluded Transaction.

(iv) For the purposes of this Section 9(c):

(A) "Exchange Act" shall mean the Securities Exchange Act of 1934, as amended from time to time.

(B) "Excluded Person" shall mean (a) any person described in and satisfying the conditions of Rule 13d-l(b)(l) under the Exchange Act, (b) the Company, (c) an employee benefit plan (or related trust) sponsored or maintained by the Company or the Successor Entity, or (d) any person who is the beneficial owner (as defined in Rule 13d-3 under the Exchange Act) of more than [25%] of the Common Stock on the Effective Date (or an affiliate, successor, heir, descendant, or related party of or to such person).

(C) "Subsidiary" shall mean any corporation or other entity a majority of whose outstanding voting stock or voting power is beneficially owned, directly or indirectly, by the Company.

(c) Executive shall have no duty to mitigate damages and none of the payments provided in this Section 9 shall be reduced by any amounts earned or received by Executive from a third party at any time. Notwithstanding anything to the contrary in this Section 9, if, in connection with a Change in Control Event, Executive voluntarily enters a new written employment agreement with the Company or the Successor Entity, Executive may no longer rely upon the provisions of this Section 9.

10. CONFIDENTIALITY

Executive will not at any time (whether during or after his employment with the Company), unless compelled by lawful process, disclose or use for his own benefit or purposes or the benefit or purposes of any other person, firm, partnership, joint venture, association, corporation or other business organization, entity or enterprise other than the Company and any of its subsidiaries or affiliates, any trade secrets, or other confidential data or information relating to customers, development programs, costs, marketing, trading, investment, sales activities, promotion, credit and financial data, financing methods, or plans of the Company or of any subsidiary or affiliate of the Company; provided that the foregoing shall not apply to information which is not unique to the Company or which is generally known to the industry or the public other than as a result of Executive's breach of this covenant. Executive agrees that upon termination of his employment with the Company for any reason, he will return to the Company immediately all memoranda, books, papers, plans, information, letters and other data, and all copies thereof or therefrom, in any way relating to the business of the Company and its affiliates, except that he may retain personal notes, notebooks and diaries that do not contain confidential information of the type described in the preceding sentence. Executive further agrees that he will not retain or use for his account at any time any trade names, trademark or other proprietary business designation used or owned in connection with the business of the Company or its affiliates.

11. NON-SOLICITATION AND NON-DISPARAGEMENT

During the Period of Employment and for a period of eighteen (18) months thereafter, Executive will not, directly or indirectly: (a) solicit or attempt to solicit any employee of the Company to terminate his or her relationship with the Company in order to become an employee, consultant or independent contractor to or for any other person or business entity; (b) solicit customers, suppliers or clients of the Company to reduce or discontinue their business with the Company or to engage in business with any competing entity; (c) disparage the Company, its business, or its reputation; or (d) otherwise disrupt or interfere with business relationships (whether formed before or after the date of this Agreement) between the Company or any of its affiliates and customers, suppliers, partners, members or investors of the Company or its affiliates.

12. RELEASE REQUIRED FOR SEVERANCE PAYMENTS

Notwithstanding anything to the contrary in this Agreement, as a condition precedent to the receipt of any payment under Section 6, Section 7, or Section 9 of this Agreement pursuant to Executive's termination of employment with the Company, Executive shall be required to execute a general waiver and release agreement, in form drafted by and satisfactory to the Company, providing for the complete waiver, release, and discharge of all known and unknown present and future claims against the Company.

13. SECTION 280G

(a) SHAREHOLDER APPROVAL REQUIRED.

Notwithstanding anything to the contrary in this Agreement, Section 13 of this Agreement shall not become effective in any part unless and until it is fully disclosed to and approved by a vote of the persons who own more than seventy five percent (75%) of the voting power of all outstanding capital stock of the Company.

(b) GROSS-UP.

(i) Gross-Up Payment. If, notwithstanding clause (a) above, it is determined (pursuant to Section 13(b)(ii)) or finally determined (as defined in Section 13(b)(iii)) that any payment, distribution, transfer, or benefit by the Company or a direct or indirect subsidiary or affiliate of the Company, to or for the benefit of Executive or Executive's dependents, heirs or beneficiaries (whether such payment, distribution, transfer, benefit or other event occurs pursuant to the terms of this Agreement or otherwise, but determined without regard to any additional payments required under this Section 13(b)) (each a "Payment" and collectively the "Payments") is subject to the excise tax imposed by Section 4999 of the Code, and any successor provision or any comparable provision of state or local income tax law (collectively, "Section 4999"), or any interest, penalty or addition to tax is incurred by Executive with respect to such excise tax (such excise tax, together with any such interest, penalty, and addition to tax, hereinafter collectively referred to as the "Excise Tax"), then, within ten (10) days after such determination or final determination, as the case may be, the Company shall pay to Executive (or to the applicable taxing authority on Executive's behalf) an additional cash payment (hereinafter referred to as the "Gross-Up Payment") equal to an amount such that after payment by Executive of all taxes, interest, penalties, additions to tax and costs imposed or incurred with respect to the Gross-Up Payment (including, without limitation, any income and excise taxes imposed upon the Gross-Up Payment), Executive retains an amount of the Gross-Up Payment equal to the Excise Tax imposed upon such Payment or Payments. This provision is intended to put Executive in the same position as Executive would have been had no Excise Tax been imposed upon or incurred as a result of any Payment.

(ii) Determination of Gross-Up.

(A) Except as provided in Section 13(b)(iii), the determination that a Payment is subject to an Excise Tax shall be made in writing by the principal certified public accounting firm then retained by the Company to audit its annual financial statements (the "Accounting Firm"). Such determination shall include the amount of the Gross-Up Payment and detailed computations thereof, including any assumptions used in such computations. Any determination by the Accounting Firm will be binding on the Company and Executive.

(B) For purposes of determining the amount of the Gross-Up Payment, Executive shall be deemed to pay Federal income taxes at the highest marginal rate of Federal income taxation in the calendar year in which the Gross-Up Payment is to be made. Such highest marginal rate shall take into account the loss

of itemized deductions by Executive and shall also include Executive's share of the hospital insurance portion of FICA and state and local income taxes at the highest marginal rate of taxation in the state and locality of Executive's residence on the date of his or her Qualifying Termination Event, net of the maximum reduction in Federal income taxes that could be obtained from the deduction of such state and local taxes.

(iii) Notification.

(A) Executive shall notify the Company in writing of any claim by the Internal Revenue Service (or any successor thereof) or any state or local taxing authority (individually or collectively, the "Taxing Authority") that, if successful, would require the payment by the Company of a Gross-Up Payment. Such notification shall be given as soon as practicable but no later than thirty (30) days after Executive receives written notice of such claim and shall apprise the Company of the nature of such claim and the date on which such claim is requested to be paid; provided, however, that failure by Executive to give such notice within such thirty (30) day period shall not result in a waiver or forfeiture of any of Executive's rights under this Section 13(b) except to the extent of actual damages suffered by the Company as a result of such failure. Executive shall not pay such claim prior to the expiration of the fifteen (15) day period following the date on which Executive gives such notice to the Company (or such shorter period ending on the date that any payment of taxes, interest, penalties or additions to tax with respect to such claim is due). If the Company notifies Executive in writing prior to the expiration of such fifteen (15) day period (regardless of whether such claim was earlier paid as contemplated by the preceding parenthetical) that it desires to contest such claim, Executive shall:

(1) give the Company any information reasonably requested by the Company relating to such claim;

(2) take such action in connection with contesting such claim as the Company shall reasonably request in writing from time to time, including, without limitation, accepting legal representation with respect to such claim by an attorney selected by the Company;

(3) cooperate with the Company in good faith in order effectively to contest such claim; and

(4) permit the Company to participate in any proceedings relating to such claim;

provided, however, that the Company shall bear and pay directly all attorneys fees, costs and expenses (including additional interest, penalties and additions to tax) incurred in connection with such contest and shall indemnify and hold Executive harmless, on an after-tax basis, for all taxes (including, without

limitation, income and excise taxes), interest, penalties and additions to tax imposed in relation to such claim and in relation to the payment of such costs and expenses or indemnification.

(B) Without limitation on the foregoing provisions of this Section 13(b)(iii), and to the extent its actions do not unreasonably interfere with or prejudice Executive's disputes with the Taxing Authority as to other issues, the Company shall control all proceedings taken in connection with such contest and, in its or their reasonable discretion, may pursue or forego any and all administrative appeals, proceedings, hearings and conferences with the Taxing Authority in respect of such claim and may, at its or in their sole option, either direct Executive to pay the tax, interest or penalties claimed and sue for a refund or contest the claim in any permissible manner, and Executive agrees to prosecute such contest to a determination before any administrative tribunal, in a court of initial jurisdiction and in one or more appellate courts, as the Company shall determine; provided, however, that if the Company directs Executive to pay such claim and sue for a refund, the Company shall advance an amount equal to such payment to Executive, on an interest-free basis, and shall indemnify and hold Executive harmless, on an after-tax basis, from all taxes (including, without limitation, income and excise taxes), interest, penalties and additions to tax imposed with respect to such advance or with respect to any imputed income with respect to such advance, as any such amounts are incurred; and, further, provided, that any extension of the statute of limitations relating to payment of taxes, interest, penalties or additions to tax for the taxable year of Executive with respect to which such contested amount is claimed to be due is limited solely to such contested amount; and, provided, further, that any settlement of any claim shall be reasonably acceptable to Executive, and the Company's control of the contest shall be limited to issues with respect to which a Gross-Up Payment would be payable hereunder, and Executive shall be entitled to settle or contest, as the case may be, any other issue.

(C) If, after receipt by Executive of an amount advanced by the Company pursuant to Section 13(b)(iii)(A), Executive receives any refund with respect to such claim, Executive shall (subject to the Company's complying with the requirements of this Section 13(b)) promptly pay to the Company an amount equal to such refund (together with any interest paid or credited thereof after taxes applicable thereto), net of any taxes (including, without limitation, any income or excise taxes), interest, penalties or additions to tax and any other costs incurred by Executive in connection with such advance, after giving effect to such repayment. If, after the receipt by Executive of an amount advanced by the Company pursuant to Section 13(b)(iii)(A), it is finally determined that Executive is not entitled to any refund with respect to such claim, then such advance shall be forgiven and shall not be required to be repaid and the amount of such advance shall be treated as a Gross-Up Payment and shall offset, to the extent thereof, the amount of any Gross-Up Payment otherwise required to be paid.

(D) For purposes of this Section 13(b), whether the Excise Tax is applicable to a Payment shall be deemed to be "finally determined" upon the earliest of: (1) the expiration of the fifteen (15) day period referred to in Section 13(b)(iii)(A) if the Company or Executive's Company has not notified Executive that it intends to contest the underlying claim, (2) the expiration of any period following which no right of appeal exists, (3) the date upon which a closing agreement or similar agreement with respect to the claim is executed by Executive and the Taxing Authority (which agreement may be executed only in compliance with this section), or (4) the receipt by Executive of notice from the Company that it no longer seeks to pursue a contest (which shall be deemed received if the Company does not, within fifteen (15) days following receipt of a written inquiry from Executive, affirmatively indicate in writing to Executive that the Company intends to continue to pursue such contest).

It is possible that no Gross-Up Payment will initially be made but that a Gross-Up Payment should have been made, or that a Gross-Up Payment will initially be made in an amount that is less than what should have been made (either of such events is referred to as an "Underpayment"). It is also possible that a Gross-Up Payment will initially be made in an amount that is greater than what should have been made (an "Overpayment"). The determination of any Underpayment or Overpayment shall be made by the Accounting Firm in accordance with Section 13(b)(ii). In the event of an Underpayment, the amount of any such Underpayment shall be paid to Executive as an additional Gross-Up Payment. In the event of an Overpayment, any such Overpayment shall be treated for all purposes as a loan to Executive with interest at the applicable Federal rate provided for in Section 1274(d) of the Code. In such case, the amount of the loan shall be subject to reduction to the extent necessary to put Executive in the same after-tax position as if such Overpayment were never made. The amount of any such reduction to the loan shall be determined by the Accounting Firm in accordance with the principles set forth in Section 13(b)(ii). Executive shall repay the amount of the loan (after reduction, if any) to the Company as soon as administratively practicable after the Company notifies Executive of (x) the Accounting Firm's determination that an Overpayment was made and (y) the amount to be repaid.

14. CONTRACT REIMBURSEMENT

The Company shall reimburse Executive on a fully grossed-up, after-tax basis or directly pay for all reasonable legal fees and costs attributed to the development, reviews and modifications of this Agreement and associated legal services. Such fees and costs shall not exceed two thousand five hundred dollars ($2,500). This Section 14 shall not be deemed to limit any of Executive's rights under Section 23 ("Attorneys' Fees").

15. ASSIGNMENT

This Agreement is personal in its nature and neither of the parties hereto shall, without the consent of the other, assign or transfer this Agreement or any rights or obligations hereunder; provided, however, that, in the event of a merger, consolidation, or transfer or sale of all or substantially all of the assets of the Company with or to any other individual(s) or entity, this Agreement shall, subject to the provisions hereof, be binding upon and inure to the benefit of

such successor and such successor shall discharge and perform all the promises, covenants, duties, and obligations of the Company hereunder.

16. GOVERNING LAW

This Agreement and the legal relations hereby created between the parties hereto shall be governed by and construed under and in accordance with the internal laws of the State of California, without regard to conflicts of laws principles thereof.

17. ENTIRE AGREEMENT

This Agreement embodies the entire agreement of the parties hereto respecting the matters within its scope. This Agreement supersedes all prior agreements of the parties hereto on the subject matter hereof. Any prior negotiations, correspondence, agreements, proposals, or understandings relating to the subject matter hereof shall be deemed to be merged into this Agreement and to the extent inconsistent herewith, such negotiations, correspondence, agreements, proposals, or understandings shall be deemed to be of no force or effect. There are no representations, warranties, or agreements, whether express or implied, or oral or written, with respect to the subject matter hereof, except as set forth herein.

18. MODIFICATIONS

This Agreement shall not be modified by any oral agreement, either express or implied, and all modifications hereof shall be in writing and signed by the parties hereto.

19. WAIVER

Failure to insist upon strict compliance with any of the terms, covenants, or conditions hereof shall not be deemed a waiver of such term, covenant, or condition, nor shall any waiver or relinquishment of, or failure to insist upon strict compliance with, any right or power hereunder at any one or more times be deemed a waiver or relinquishment of such right or power at any other time or times.

20. NUMBER AND GENDER

Where the context requires, the singular shall include the plural, the plural shall include the singular, and any gender shall include all other genders.

21. SECTION HEADINGS

The section headings in this Agreement are for the purpose of convenience only and shall not limit or otherwise affect any of the terms hereof.

22. ARBITRATION

Any controversy arising out of or relating to Executive's employment, this Agreement, its enforcement or interpretation, or because of an alleged breach, default, or misrepresentation in connection with any of its provisions, shall be submitted to arbitration in Los Angeles County, California, before a sole arbitrator who is either (a) a member of the National Academy of Arbitrators located in the State of California or (b) a retired California Superior Court or Appellate Court judge, and shall be conducted in accordance with the provisions of California Civil Procedure, Code Sections 1280 et seq. as the exclusive remedy of such dispute; provided, however, that provisional injunctive relief may, but need not, be sought in a court of law while arbitration proceedings are pending, and any provisional injunctive relief granted by such court shall remain effective until the matter is finally determined by the Arbitrator. Final resolution of any dispute through arbitration may include any remedy or relief which the Arbitrator deems just and equitable. Any award or relief granted by the Arbitrator hereunder shall be final and binding on the parties hereto and may be enforced by any court of competent jurisdiction. The parties acknowledge and agree that they are hereby waiving any rights to trial by jury in any action, proceeding or counterclaim brought by either of the parties against the other in connection with any matter whatsoever arising out of or in any way connected with this Agreement or Executive's employment.

23. ATTORNEYS' FEES

Executive and the Company agree that in any dispute resolution proceedings arising out of this Agreement, the prevailing party shall be entitled to its or his reasonable attorneys' fees and costs incurred by it or him in connection with resolution of the dispute in addition to any other relief granted.

24. SEVERABILITY

In the event that a court of competent jurisdiction determines that any portion of this Agreement is in violation of any statute or public policy, then only the portions of this Agreement which violate such statute or public policy shall be stricken, and all portions of this Agreement which do not violate any statute or public policy shall continue in full force and effect. Furthermore, any court order striking any portion of this Agreement shall modify the stricken terms as narrowly as possible to give as much effect as possible to the intentions of the parties under this Agreement.

25. NOTICES

All notices under this Agreement shall be in writing and shall be either personally delivered or mailed postage prepaid, by certified mail, return receipt requested:

(a) if to the Company:

Molina Healthcare, Inc.
Attention: J. Mario Molina, M.D., President and Chief Executive Officer
One Golden Shore Drive
Long Beach, California 90802

(b) if to Executive:

Mark L. Andrews
570 Morris Way
Sacramento, CA 95864

Notice shall be effective when personally delivered, or five (5) business days after being so mailed, or when transmitted via facsimile with confirmation of receipt.

26. COUNTERPARTS

This Agreement may be executed in any number of counterparts, each of which shall be deemed an original and all of which together shall constitute one and the same instrument.

27. WITHHOLDING TAXES

The Company may withhold from any amounts payable under this Agreement such federal, state and local taxes as may be required to be withheld pursuant to any applicable law or regulation.

IN WITNESS WHEREOF, the Company and Executive have executed this Employment Agreement as of the date first above written.

"COMPANY"
Molina Healthcare, Inc.

By: /s/

J. Mario Molina, M.D.
Chairman, President, and
Chief Executive Officer

"EXECUTIVE"
Mark L. Andrews

/s/

Mark L. Andrews

EXHIBIT 10.10

EMPLOYMENT AGREEMENT

This Employment Agreement (this "Agreement") is made as of December 31, 2001, between Dr. George Goldstein ("Executive") and Molina Healthcare, Inc. (the "Company").

RECITALS

The Company desires to establish its right to the services of Executive in the capacities described below, on the terms and conditions hereinafter set forth, and Executive is willing to accept such employment on such terms and conditions. The parties hereto have previously entered into an Employment Agreement dated November 9, 1998 (the "Existing Agreement"), and this Agreement supercedes the Existing Agreement.

AGREEMENT

The parties agree as follows:

1. DUTIES

(a) The Company does hereby hire, engage, and employ Executive as Executive Vice President of the Company, and Executive does hereby accept and agree to such hiring, engagement, and employment. During the Period of Employment (as defined in Section 2), Executive shall serve the Company in such position in conformity with the provisions of this Agreement, directives of the Chief Executive Officer and the corporate policies of the Company as they presently exist, and as such policies may be amended, modified, changed, or adopted during the Period of Employment. Executive shall have duties and authority consistent with Executive's position as Executive Vice President and shall report to the Chief Executive Officer of the Company (the "Reporting Relationship").

(b) Throughout the Period of Employment, Executive shall devote his time, energy, and skill to the performance of his duties for the Company, vacations and other leave authorized under this Agreement excepted. Notwithstanding the foregoing, Executive shall be permitted to (i) engage in charitable and community affairs and (ii) make direct investments of any character in any non-competing business or businesses and to manage such investments (but not be involved in the day-to-day operations of any such business); provided, in each case, and in the aggregate, that such activities do not materially interfere with the performance of Executive's duties hereunder, and further provided that Executive may invest in a publicly traded competing business so long as such investment does not equal or exceed one percent of the outstanding shares of such publicly traded competing business.

(c) Executive hereby represents to the Company that the execution and delivery of this Agreement by Executive and the Company and the performance by Executive of Executive's duties hereunder shall not constitute a breach of, or otherwise contravene, the terms of any employment or other agreement or policy to which Executive is a party or otherwise bound.

2. PERIOD OF EMPLOYMENT

The "Period of Employment" shall, unless sooner terminated as provided herein, be a period commencing on December 1, 2001 (the "Effective Date") and ending with the close of business on December 1, 2004. Notwithstanding the preceding sentence, commencing with December 1, 2004 and on each December 1st thereafter (each an "Extension Date"), the Period of Employment shall be automatically extended for an additional one-year period so as to expire one year from such Extension Date, unless: (i) the Company or Executive provides the other party hereto ninety (90) days' prior written notice before the next scheduled Extension Date that the Period of Employment shall not be so extended (the "Non-Extension Notice"); or (ii) Executive is not less than sixty-five (65) years of age as of the next scheduled Extension Date. The term "Period of Employment" shall include any extension that becomes applicable pursuant to the preceding sentence.

3. COMPENSATION

(a) BASE SALARY. Executive's Base Salary shall be at a rate of not less than $358,400 annually ("Executive's Base Salary"), paid in accordance with regular payroll practices, but not less than monthly. The CEO shall review at least annually Executive's Base Salary for possible increase in accordance with the Company's customary review practices for its senior executives and may, in his sole discretion, periodically adjust Executive's Base Salary to reflect individual performance. In the event of an increase, Executive's Base Salary for the year in which the increase occurs shall be adjusted on a pro rata basis to reflect the increase.

(b) BONUS. Executive shall be eligible to earn an annual discretionary bonus for each fiscal year of the Company (an "Annual Bonus"), with a target Annual Bonus (the "Target Bonus") of forty-five percent (45%) of his Base Salary, to be awarded at the sole discretion of the CEO based on the achievement of certain mutually agreed upon objectives. Executive shall be entitled to participate in all bonus or incentive plans applicable to the senior executives of the Company, including without limitation any Effective Option Plan (as defined in Section 4(e)). CEO may in his sole discretion, also award to Executive such extraordinary bonus(es) as CEO deems appropriate.

4. BENEFITS

(a) HEALTH AND WELFARE. During the Period of Employment, Executive shall be entitled to participate, on the same terms and at the same level as other executives, in all health and welfare benefit plans and programs generally available to other executives or employees of the Company (including, without limitation, the Company's medical, dental, vision, life benefits, life insurance, and long-term disability plans) as in effect from time to time and to receive any special benefits (long-term care insurance) provided from time to time, subject to any legally required restrictions specified in such plans and programs. Without limiting the generality of the foregoing, Company shall provide life insurance for Executive, with Executive to designate the beneficiary thereunder, in an amount equal to Executive's base salary as in effect on the date of this Agreement and as in effect on the first business day of each calendar year thereafter.

(b) PAID TIME OFF AND OTHER LEAVE. During the Period of Employment, Executive shall receive 10.77 hours of paid time off per "pay period" of the Company (the "PTO"), subject to the Company's policies concerning accrual of PTO and provided that for any three hundred sixty five (365) day period within the Period of Employment Executive shall earn no less than a total of thirty five (35) days of PTO. Executive shall also be entitled to all other holiday and leave pay generally available to other executives of the Company.

(c) TRAVEL AND EXPENSE REIMBURSEMENTS. During the Period of Employment, Company will reimburse Executive for all reasonable expenses incurred in connection with performance of his duties under section 1 of this Agreement in accordance with the Company's expense reimbursement policies.

(d) RETIREMENT. During the Period of Employment, Executive shall be eligible to participate on the same terms and at the same level as other executives, in all retirement, 401(k), deferred compensation, or other savings plans generally available to other executives, or employees of the Company as in effect from time to time, subject to any legally required restrictions specified in such plans and programs.

(e) EQUITY GRANTS.

(i) Initial Options. Executive shall, on the Effective Date, be granted stock options for 4,000 shares of the common stock of the Company (the "Initial Options") pursuant to the option agreement. The first 1,000 shares vesting on December 31, 2001. The exercise price of the Initial Options will be $180 per share. The Initial Options are subject to the terms and conditions of the "Option Plan".

(ii) Future Options. Executive shall be eligible, at the sole discretion of the Board, for additional annual stock option grants (the "Future Options") pursuant to one or more additional option agreements. Any Future Options will be granted under and subject to the terms and conditions of the stock option plan of the Company. The terms and conditions of such Future Options are intended to be such that Executive shall receive a compensation package commensurate with executives performing the same functions as Executives for businesses similar to the Company.

(f) OTHER BENEFITS. In addition to benefits specifically provided herein, during the Period of Employment, Executive shall be entitled to participate, on the same terms and at the same level as other executives, in all fringe benefit plans and perquisites provided by Company to its executives.

The employee benefits described in Sections 4(a) through (f) inclusive are referred to as "Executive Benefits."

5. DEATH OR DISABILITY

(a) PERMANENTLY DISABLED AND PERMANENT DISABILITY. The terms "Permanently Disabled" and "Permanent Disability" shall mean Executive's inability, because of physical or mental illness or injury, to perform the essential functions of his customary duties pursuant to this Agreement, with or without reasonable accommodation, and the continuation of such disabled condition for a period of twelve (12) months.

(b) TERMINATION DUE TO DEATH OR DISABILITY. If Executive dies or becomes Permanently Disabled during the Period of Employment, the Period of Employment and Executive's employment shall automatically cease and terminate as of the date of Executive's death or the date of Permanent Disability as determined by the Board (which date shall be referred to as the "Disability Date"), as the case may be. In the event of the termination of the Period of Employment and Executive's employment hereunder due to Executive's death or Permanent Disability, Executive or his estate shall be entitled to receive:

(i) Within five (5) business days, a lump sum cash payment equal to the sum of (x) any accrued but unpaid Base Salary and PTO as of the Termination Date hereunder and (y) any unpaid annual incentive compensation in respect of the most recently completed fiscal year preceding the Termination Date (the "Unpaid Annual Bonus"); and

(ii) Within thirty (30) days, such employee benefits described in Sections 4(a) and 4(c) through 4(f) inclusive, if any, as to which Executive may be entitled as of the Termination Date under the employee benefit plans and arrangements of the Company ((i) and (ii) collectively, the "Accrued Obligations").

6. TERMINATION BY THE COMPANY

(a) TERMINATION FOR CAUSE. The Company may terminate for Cause (as defined below) at any time the Period of Employment and Executive's employment hereunder by providing to Executive written notice of such termination ("Notice of Termination for Cause"). The term "Cause" shall mean a termination of service based upon a finding by the Company, acting in good faith and based on its reasonable belief at the time, that Executive:

(i) has engaged in unlawful acts involving moral turpitude or gross negligence with respect to the Company;

(ii) has consistently and willfully failed to perform his duties or has intentionally breached any material provision of any agreement with the Company or an affiliated entity; provided, however, that such failure or breach shall not constitute Cause unless it is (A) not reasonably curable or (B) if reasonably curable, is not cured by the Executive within thirty (30) days notice from the Company;

If the Executive's employment is terminated for Cause, the termination shall take effect on the Termination Date (as defined below). In the event of termination of the Period of Employment and Executive's employment hereunder due to a termination by the Company for Cause, Executive shall be entitled to receive the Accrued Obligations. All of the Accrued

Obligations shall be paid on the Termination Date except those benefits described in Sections 4(a) and 4(c) through (f) inclusive, which shall be paid within thirty (30) days of the Termination Date.

If the Company attempts to terminate Executive's employment pursuant to this Section 6(a) and it is ultimately determined that the Company lacked Cause, the provisions of Section 6(b) ("Termination by the Company-Termination Without Cause") shall apply as if the Company had provided Executive with Notice of Termination Without Cause (as defined below) on the date the Company actually provided Executive with Notice of Termination for Cause.

(b) TERMINATION WITHOUT CAUSE. The Company may, without cause or reason, terminate at any time the Period of Employment and Executive's employment hereunder by providing Executive written notice of such termination ("Notice of Termination Without Cause"). A Non-Extension Notice by the Company shall be considered a termination without Cause. If Executive's employment is terminated without Cause, the termination shall take effect on the Termination Date. In the event of the termination of Executive's employment hereunder due to a termination by the Company without Cause (other than due to Executive's death or Permanent Disability):

(i) Executive shall be entitled to receive: (1) an amount equal to 100% of the sum of (x) Executive's Base Salary then in effect as of the Termination Date and (y) the Target Bonus for the fiscal year in which Executive's employment is terminated (the "Severance Payment"); (2) a pro rata portion of the Target Bonus for the fiscal year in which Executive's employment is terminated, based on the number of entire months of such fiscal year that have elapsed through the date of Executive's termination of employment as a fraction of twelve (12) (the "Pro Rata Bonus"); (3) the Accrued Obligations; (4) the entirety of Executive's contributions and the Company's contributions to Executive's 401(k) plan account as if Executive were fully vested as of the Termination Date, and (5) all other benefits under the welfare benefit and retirement plans contemplated by Sections 4(a) and 4(d) (the "Selected Benefits") until the earlier of (A) Executive's receipt of benefits substantially similar in scope and nature from another employer or (B) one year and one-half year after the Termination Date.

(ii) Executive shall be entitled to one hundred percent vesting of all of the options (including, without limitation, Existing Options, Initial Options, and Future Options) to purchase common stock of the Company ("Common Stock") held by Executive as of the Termination Date (the "Options").

(iii) Company shall, upon the written request of Executive (the "Executive Put Option") be required to repurchase all shares of Common Stock acquired by Executive pursuant to the exercise of stock options granted to and/or held by Executive as of the Termination Date (the "Executive Shares"). Executive may not exercise the Executive Put Option with respect to Executive Shares within the six-month period following the date Executive acquired such Executive Shares, and the Executive Put Option may not be exercised at any time after the Company becomes publicly traded. The repurchase price for each Executive Share shall be equal to the fair market value of a share of Common Stock ("Fair Market Value"), which Fair Market Value:

(A) shall be determined as of the date of the exercise of Executive Put Option by an independent appraiser chosen by the Company and Executive as follows: the Company shall identify three appraisers independent of the Company, and Executive shall select one from the three identified; and

(B) shall be determined without any minority, illiquidity or other discount.

(iv) Amounts payable under this Section 6(b) shall be payable as follows:

(A) amounts payable under clause (i) shall be, or shall commence to be, paid within 30 days following the Termination Date either in a single lump sum or in regular installments as a continuation of Executive's salary according to the Company's customary payroll practices, as determined by the Executive in his sole discretion; provided however that any amounts representing accrued but unpaid Executive Base Salary, PTO an Unpaid Annual Bonus shall be paid on the Termination Date.

(B) Amounts payable under clause (iii) that are attributable to the exercise of Initial Options and/or Future Options shall be paid by the Company in three annual lump sum installments as follows: (1) within 30 days after the Termination Date, one-third of the payout; (2) on the first anniversary of the Termination Date, one-third of the payout, with interest on the previously unpaid portion of the payout accrued from the Termination Date at the applicable federal rate; and (3) on the second anniversary of the Termination Date, the remaining one-third of the payout, with interest on such previously unpaid portion of the payout accrued from the first anniversary of the Termination Date at the applicable federal rate.

Executive shall have no duty to mitigate damages and none of the payments provided in this Section 6(b) shall be reduced by any amounts earned or received by Executive from a third party at any time.

7. TERMINATION BY EMPLOYEE

(a) TERMINATION WITHOUT GOOD REASON. Executive shall have the right to terminate the Period of Employment and Executive's employment hereunder at any time without Good Reason (as defined below) upon fifteen (15) days prior written notice of such termination to the Company. A Non-Extension Notice by Executive shall be considered a termination without Good Reason. Any such termination by Executive without Good Reason shall be treated for all purposes of this Agreement as a termination by the Company for Cause and the provisions of Section 6(a) shall apply, provided, however, that notwithstanding the foregoing, if Executive terminates the Period of Employment without Good Reason, Executive shall be allowed to exercise the Executive Put Option with respect to Executive Shares received pursuant to the exercise of Existing Options, subject to the terms and conditions generally applicable with respect to the Executive Put Option.

(b) TERMINATION WITH GOOD REASON. Executive may terminate the Period of Employment and resign from employment hereunder for "Good Reason." "Good Reason" shall mean (with or without regard to whether a Change in Control Event has occurred), without obtaining Executive's prior written consent thereto:

(i) a material and adverse change in Executive's position, duties, responsibilities, Reporting Relationship or status with the Company,

(ii) a change in Executive's office location to a point more than fifty (50) miles from Executive's current office,

(iii) the taking of any action by the Company to: (A) eliminate benefit plans applicable to Executive without providing substitutes which provide a substantially similar aggregate value of benefits, (B) materially reduce Executive's benefits thereunder or (C) substantially diminish the aggregate value to Executive of incentive awards or other fringe benefits, provided, however, that it shall not constitute Good Reason for the Company to, as part of an overall cost-reduction program, take any action described in (A)-(C) so long as such action is taken with respect to all senior executives and Executive is not disproportionately affected thereby,

(iv) any reduction in the Base Salary, provided, however, that it shall not constitute Good Reason for the Company to, as part of an overall cost-reduction program, reduce Executive's Base Salary so long as the base salaries of all other senior executives are simultaneously reduced by not less than the same percentage, or

(v) any breach of this Agreement by the Company or any successor thereto, including without limitation any failure by the Company to obtain the consent of any Successor Entity (as defined below) to the provisions contained in Section 9; provided, however, that none of the events described in clause (v) of this Section 7(b) shall constitute Good Reason unless Executive shall have notified the Company in writing describing the events which constitute Good Reason and then only if the Company shall have failed to cure such event within thirty (30) days after the Company's receipt of such written notice.

Any such termination by Executive for Good Reason shall be treated for all purposes of this Agreement as a termination by the Company without Cause and the provisions of Section 6(b) shall apply; provided, however, that if Executive attempts to resign for Good Reason pursuant to this Section 7(b) and it is ultimately determined that Good Reason did not exist, Executive shall be deemed to have resigned from employment without Good Reason and the provisions of Section 7(a) and, by reference therein, the provisions of Section 6(a), shall apply.

8. TERMINATION DATE

The term "Termination Date" shall mean (i) if Executive's employment is terminated by the Company for Cause, or by Executive for Good Reason, the effective date (pursuant to Section 25 ("Notices")) of written notice of such termination to Executive or to the Company, as the case may be; (ii) if Executive's employment is terminated by the Company other than for

Cause or Disability, the date on which the Company notifies Executive of such termination; or (iii) if Executive's employment is terminated by reason of Death or Disability, the Disability Date.

9. CHANGE IN CONTROL

(a) Notwithstanding anything to the contrary in this Agreement, if a Change in Control Event (as defined below) of the Company occurs during the term of this Agreement, and if within two years following such Change in Control Event either (1) the Company terminates Executive's employment without Cause or (2) Executive terminates his employment for Good Reason:

(i) the Company shall pay to Executive an amount equal to the sum of (w) two times the Severance Payment, (x) the Pro Rata Bonus, (y) the Accrued Obligations and (z) the entirety of Executive's contributions and the Company's contributions to Executive's 401(k) plan account as if Executive were fully vested as of the Termination Date, such amount to be, or to commence to be, paid on the Termination Date either in a single lump sum or in regular installments as a continuation of Executive's salary according to the Company's customary payroll practices, as determined by the Executive in his sole discretion at the time of termination. This payment shall be in lieu of the payment otherwise payable under clause (i) of Section 6(b).

(ii) the Company shall continue to provide the Selected Benefits until the earlier of (x) Executive's receipt of benefits substantially similar in scope and nature from another employer or (y) three years after the Termination Date.

(iii) and, regardless of whether any of the Options have been assumed by any Successor Entity, the provisions of clauses (ii) and (iii) of Section 6(b) will apply.

(b) A "Change in Control Event" shall mean any of the following:

(i) Approval by the Board and by shareholders of the Company (or, if no shareholder approval is required, by the Board alone) of the dissolution or liquidation of the Company, other than in the context of a transaction that does not constitute a Change in Control Event under clause (ii) below;

(ii) Consummation of a merger, consolidation, or other reorganization, with or into, or the sale of all or substantially all of the Company's business and/or assets as an entirety to, one or more entities that are not Subsidiaries or other affiliates of the Company (a "Business Combination"), unless (1) as a result of the Business Combination, more than fifty percent (50%) of the outstanding voting power generally in the election of directors of the surviving or resulting entity or a parent thereof (the "Successor Entity") immediately after the reorganization is, or will be, owned, directly or indirectly, by holders of the Company's voting securities immediately before the Business Combination; and (2) no "person" (as such term is used in Sections 13(d) and 14(d) of the Exchange Act), excluding the Successor Entity or an Excluded Person, beneficially owns, directly or indirectly, more than fifty percent (50%) of the outstanding shares or the combined voting power of the outstanding voting securities of the Successor Entity,

after giving effect to the Business Combination, except to the extent that such ownership existed prior to the Business Combination; or

(iii) Any "person" (as such term is used in Sections 13(d) and 14(d) of the Exchange Act) other than an Excluded Person: (a) becomes the beneficial owner (as defined in Rule 13d-3 under the Exchange Act), directly or indirectly, of securities of the Company representing more than fifty percent (50%) of the combined voting power of the Company's then outstanding securities entitled to then vote generally in the election of directors (the "Voting Power") of the Company (a "Majority Holder"), other than as a result of (1) an acquisition directly from the Company, (2) an acquisition by the Company, or (3) an acquisition by an entity pursuant to a transaction which is expressly excluded under clause (ii) above (an "Excluded Transaction"); or (b) provided that the beneficial owner of a majority of the Voting Power as of the Effective Date is no longer a Majority Holder, becomes the beneficial owner (as defined in Rule 13d-3 under the Exchange Act), directly or indirectly, of securities of the Company representing more than thirty percent (30%) of the Voting Power, other than as a result of an Excluded Transaction.

(iv) For the purposes of this Section 9(c):

(A) "Exchange Act" shall mean the Securities Exchange Act of 1934, as amended from time to time.

(B) "Excluded Person" shall mean (a) any person described in and satisfying the conditions of Rule 13d-1(b)(1) under the Exchange Act, (b) the Company, (c) an employee benefit plan (or related trust) sponsored or maintained by the Company or the Successor Entity, or (d) any person who is the beneficial owner (as defined in Rule 13d-3 under the Exchange Act) of more than [25%] of the Common Stock on the Effective Date (or an affiliate, successor, heir, descendant, or related party of or to such person).

(C) "Subsidiary" shall mean any corporation or other entity a majority of whose outstanding voting stock or voting power is beneficially owned, directly or indirectly, by the Company.

(c) Executive shall have no duty to mitigate damages and none of the payments provided in this Section 9 shall be reduced by any amounts earned or received by Executive from a third party at any time. Notwithstanding anything to the contrary in this Section 9, if, in connection with a Change in Control Event, Executive voluntarily enters a new written employment agreement with the Company or the Successor Entity, Executive may no longer rely upon the provisions of this Section 9.

10. CONFIDENTIALITY

Executive will not at any time (whether during or after his employment with the Company), unless compelled by lawful process, disclose or use for his own benefit or purposes or the benefit or purposes of any other person, firm, partnership, joint venture, association, corporation or other business organization, entity or enterprise other than the Company and any of its subsidiaries or affiliates, any trade secrets, or other confidential data or information relating

to customers, development programs, costs, marketing, trading, investment, sales activities, promotion, credit and financial data, financing methods, or plans of the Company or of any subsidiary or affiliate of the Company; provided that the foregoing shall not apply to information which is not unique to the Company or which is generally known to the industry or the public other than as a result of Executive's breach of this covenant. Executive agrees that upon termination of his employment with the Company for any reason, he will return to the Company immediately all memoranda, books, papers, plans, information, letters and other data, and all copies thereof or therefrom, in any way relating to the business of the Company and its affiliates, except that he may retain personal notes, notebooks and diaries that do not contain confidential information of the type described in the preceding sentence. Executive further agrees that he will not retain or use for his account at any time any trade names, trademark or other proprietary business designation used or owned in connection with the business of the Company or its affiliates.

11. NON-SOLICITATION AND NON-DISPARAGEMENT

During the Period of Employment and for a period of eighteen (18) months thereafter, Executive will not, directly or indirectly: (a) solicit or attempt to solicit any employee of the Company to terminate his or her relationship with the Company in order to become an employee, consultant or independent contractor to or for any other person or business entity; (b) solicit customers, suppliers or clients of the Company to reduce or discontinue their business with the Company or to engage in business with any competing entity; (c) disparage the Company, its business, or its reputation; or (d) otherwise disrupt or interfere with business relationships (whether formed before or after the date of this Agreement) between the Company or any of its affiliates and customers, suppliers, partners, members or investors of the Company or its affiliates.

12. RELEASE REQUIRED FOR SEVERANCE PAYMENTS

Notwithstanding anything to the contrary in this Agreement, as a condition precedent to the receipt of any payment under Section 6, Section 7, or Section 9 of this Agreement pursuant to Executive's termination of employment with the Company, Executive shall be required to execute a general waiver and release agreement, in form drafted by and satisfactory to the Company, providing for the complete waiver, release, and discharge of all known and unknown present and future claims against the Company.

13. SECTION 280G

(a) SHAREHOLDER APPROVAL REQUIRED.

Notwithstanding anything to the contrary in this Agreement, Section 13 of this Agreement shall not become effective in any part unless and until it is fully disclosed to and approved by a vote of the persons who own more than seventy five percent (75%) of the voting power of all outstanding capital stock of the Company.

(b) GROSS-UP.

(i) Gross-Up Payment. If, notwithstanding clause (a) above, it is determined (pursuant to Section 13(b)(ii)) or finally determined (as defined in Section 13(b)(iii)) that any payment, distribution, transfer, or benefit by the Company or a direct or indirect subsidiary or affiliate of the Company, to or for the benefit of Executive or Executive's dependents, heirs or beneficiaries (whether such payment, distribution, transfer, benefit or other event occurs pursuant to the terms of this Agreement or otherwise, but determined without regard to any additional payments required under this Section 13(b)) (each a "Payment" and collectively the "Payments") is subject to the excise tax imposed by Section 4999 of the Code, and any successor provision or any comparable provision of state or local income tax law (collectively, "Section 4999"), or any interest, penalty or addition to tax is incurred by Executive with respect to such excise tax (such excise tax, together with any such interest, penalty, and addition to tax, hereinafter collectively referred to as the "Excise Tax"), then, within ten (10) days after such determination or final determination, as the case may be, the Company shall pay to Executive (or to the applicable taxing authority on Executive's behalf) an additional cash payment (hereinafter referred to as the "Gross-Up Payment") equal to an amount such that after payment by Executive of all taxes, interest, penalties, additions to tax and costs imposed or incurred with respect to the Gross-Up Payment (including, without limitation, any income and excise taxes imposed upon the Gross-Up Payment), Executive retains an amount of the Gross-Up Payment equal to the Excise Tax imposed upon such Payment or Payments. This provision is intended to put Executive in the same position as Executive would have been had no Excise Tax been imposed upon or incurred as a result of any Payment.

(ii) Determination of Gross-Up.

(A) Except as provided in Section 13(b)(iii), the determination that a Payment is subject to an Excise Tax shall be made in writing by the principal certified public accounting firm then retained by the Company to audit its annual financial statements (the "Accounting Firm"). Such determination shall include the amount of the Gross-Up Payment and detailed computations thereof, including any assumptions used in such computations. Any determination by the Accounting Firm will be binding on the Company and Executive.

(B) For purposes of determining the amount of the Gross-Up Payment, Executive shall be deemed to pay Federal income taxes at the highest marginal rate of Federal income taxation in the calendar year in which the Gross-Up Payment is to be made. Such highest marginal rate shall take into account the loss of itemized deductions by Executive and shall also include Executive's share of the hospital insurance portion of FICA and state and local income taxes at the highest marginal rate of taxation in the state and locality of Executive's residence on the date of his or her Qualifying Termination Event, net of the maximum reduction in Federal income taxes that could be obtained from the deduction of such state and local taxes.

(iii) Notification.

(A) Executive shall notify the Company in writing of any claim by the Internal Revenue Service (or any successor thereof) or any state or local taxing authority (individually or collectively, the "Taxing Authority") that, if successful, would require the payment by the Company of a Gross-Up Payment. Such notification shall be given as soon as practicable but no later than thirty (30) days after Executive receives written notice of such claim and shall apprise the Company of the nature of such claim and the date on which such claim is requested to be paid; provided, however, that failure by Executive to give such notice within such thirty (30) day period shall not result in a waiver or forfeiture of any of Executive's rights under this Section 13(b) except to the extent of actual damages suffered by the Company as a result of such failure. Executive shall not pay such claim prior to the expiration of the fifteen (15) day period following the date on which Executive gives such notice to the Company (or such shorter period ending on the date that any payment of taxes, interest, penalties or additions to tax with respect to such claim is due). If the Company notifies Executive in writing prior to the expiration of such fifteen (15) day period (regardless of whether such claim was earlier paid as contemplated by the preceding parenthetical) that it desires to contest such claim, Executive shall:

(1) give the Company any information reasonably requested by the Company relating to such claim;

(2) take such action in connection with contesting such claim as the Company shall reasonably request in writing from time to time, including, without limitation, accepting legal representation with respect to such claim by an attorney selected by the Company;

(3) cooperate with the Company in good faith in order effectively to contest such claim; and

(4) permit the Company to participate in any proceedings relating to such claim;

provided, however, that the Company shall bear and pay directly all attorneys fees, costs and expenses (including additional interest, penalties and additions to tax) incurred in connection with such contest and shall indemnify and hold Executive harmless, on an after-tax basis, for all taxes (including, without limitation, income and excise taxes), interest, penalties and additions to tax imposed in relation to such claim and in relation to the payment of such costs and expenses or indemnification.

(B) Without limitation on the foregoing provisions of this Section 13(b)(iii), and to the extent its actions do not unreasonably interfere with or prejudice Executive's disputes with the Taxing Authority as to other issues, the

Company shall control all proceedings taken in connection with such contest and, in its or their reasonable discretion, may pursue or forego any and all administrative appeals, proceedings, hearings and conferences with the Taxing Authority in respect of such claim and may, at its or in their sole option, either direct Executive to pay the tax, interest or penalties claimed and sue for a refund or contest the claim in any permissible manner, and Executive agrees to prosecute such contest to a determination before any administrative tribunal, in a court of initial jurisdiction and in one or more appellate courts, as the Company shall determine; provided, however, that if the Company directs Executive to pay such claim and sue for a refund, the Company shall advance an amount equal to such payment to Executive, on an interest-free basis, and shall indemnify and hold Executive harmless, on an after-tax basis, from all taxes (including, without limitation, income and excise taxes), interest, penalties and additions to tax imposed with respect to such advance or with respect to any imputed income with respect to such advance, as any such amounts are incurred; and, further, provided, that any extension of the statute of limitations relating to payment of taxes, interest, penalties or additions to tax for the taxable year of Executive with respect to which such contested amount is claimed to be due is limited solely to such contested amount; and, provided, further, that any settlement of any claim shall be reasonably acceptable to Executive, and the Company's control of the contest shall be limited to issues with respect to which a Gross-Up Payment would be payable hereunder, and Executive shall be entitled to settle or contest, as the case may be, any other issue.

(C) If, after receipt by Executive of an amount advanced by the Company pursuant to Section 13(b)(iii)(A), Executive receives any refund with respect to such claim, Executive shall (subject to the Company's complying with the requirements of this Section 13(b)) promptly pay to the Company an amount equal to such refund (together with any interest paid or credited thereof after taxes applicable thereto), net of any taxes (including, without limitation, any income or excise taxes), interest, penalties or additions to tax and any other costs incurred by Executive in connection with such advance, after giving effect to such repayment. If, after the receipt by Executive of an amount advanced by the Company pursuant to Section 13(b)(iii)(A), it is finally determined that Executive is not entitled to any refund with respect to such claim, then such advance shall be forgiven and shall not be required to be repaid and the amount of such advance shall be treated as a Gross-Up Payment and shall offset, to the extent thereof, the amount of any Gross-Up Payment otherwise required to be paid.

(D) For purposes of this Section 13(b), whether the Excise Tax is applicable to a Payment shall be deemed to be "finally determined" upon the earliest of: (1) the expiration of the fifteen (15) day period referred to in Section 13(b)(iii)(A) if the Company or Executive's Company has not notified Executive that it intends to contest the underlying claim, (2) the expiration of any period following which no right of appeal exists, (3) the date upon which a closing agreement or similar agreement with respect to the claim is executed by Executive and the Taxing Authority (which agreement may be executed only in compliance

with this section), or (4) the receipt by Executive of notice from the Company that it no longer seeks to pursue a contest (which shall be deemed received if the Company does not, within fifteen (15) days following receipt of a written inquiry from Executive, affirmatively indicate in writing to Executive that the Company intends to continue to pursue such contest).

It is possible that no Gross-Up Payment will initially be made but that a Gross-Up Payment should have been made, or that a Gross-Up Payment will initially be made in an amount that is less than what should have been made (either of such events is referred to as an "Underpayment"). It is also possible that a Gross-Up Payment will initially be made in an amount that is greater than what should have been made (an "Overpayment"). The determination of any Underpayment or Overpayment shall be made by the Accounting Firm in accordance with Section 13(b)(ii). In the event of an Underpayment, the amount of any such Underpayment shall be paid to Executive as an additional Gross-Up Payment. In the event of an Overpayment, any such Overpayment shall be treated for all purposes as a loan to Executive with interest at the applicable Federal rate provided for in Section 1274(d) of the Code. In such case, the amount of the loan shall be subject to reduction to the extent necessary to put Executive in the same after-tax position as if such Overpayment were never made. The amount of any such reduction to the loan shall be determined by the Accounting Firm in accordance with the principles set forth in Section 13(b)(ii). Executive shall repay the amount of the loan (after reduction, if any) to the Company as soon as administratively practicable after the Company notifies Executive of (x) the Accounting Firm's determination that an Overpayment was made and (y) the amount to be repaid.

14. CONTRACT REIMBURSEMENT

The Company shall reimburse Executive on a fully grossed-up, after-tax basis or directly pay for all reasonable legal fees and costs attributed to the development, reviews and modifications of this Agreement and associated legal services. Such fees and costs shall not exceed two thousand five hundred dollars ($2,500). This Section 14 shall not be deemed to limit any of Executive's rights under Section 23 ("Attorneys' Fees").

15. ASSIGNMENT

This Agreement is personal in its nature and neither of the parties hereto shall, without the consent of the other, assign or transfer this Agreement or any rights or obligations hereunder; provided, however, that, in the event of a merger, consolidation, or transfer or sale of all or substantially all of the assets of the Company with or to any other individual(s) or entity, this Agreement shall, subject to the provisions hereof, be binding upon and inure to the benefit of such successor and such successor shall discharge and perform all the promises, covenants, duties, and obligations of the Company hereunder.

16. GOVERNING LAW

This Agreement and the legal relations hereby created between the parties hereto shall be governed by and construed under and in accordance with the internal laws of the State of California, without regard to conflicts of laws principles thereof.

17. ENTIRE AGREEMENT

This Agreement embodies the entire agreement of the parties hereto respecting the matters within its scope. This Agreement supersedes all prior agreements of the parties hereto on the subject matter hereof. Any prior negotiations, correspondence, agreements, proposals, or understandings relating to the subject matter hereof shall be deemed to be merged into this Agreement and to the extent inconsistent herewith, such negotiations, correspondence, agreements, proposals, or understandings shall be deemed to be of no force or effect. There are no representations, warranties, or agreements, whether express or implied, or oral or written, with respect to the subject matter hereof, except as set forth herein.

18. MODIFICATIONS

This Agreement shall not be modified by any oral agreement, either express or implied, and all modifications hereof shall be in writing and signed by the parties hereto.

19. WAIVER

Failure to insist upon strict compliance with any of the terms, covenants, or conditions hereof shall not be deemed a waiver of such term, covenant, or condition, nor shall any waiver or relinquishment of, or failure to insist upon strict compliance with, any right or power hereunder at any one or more times be deemed a waiver or relinquishment of such right or power at any other time or times.

20. NUMBER AND GENDER

Where the context requires, the singular shall include the plural, the plural shall include the singular, and any gender shall include all other genders.

21. SECTION HEADINGS

The section headings in this Agreement are for the purpose of convenience only and shall not limit or otherwise affect any of the terms hereof.

22. ARBITRATION

Any controversy arising out of or relating to Executive's employment, this Agreement, its enforcement or interpretation, or because of an alleged breach, default, or misrepresentation in connection with any of its provisions, shall be submitted to arbitration in Los Angeles County, California, before a sole arbitrator who is either (a) a member of the National Academy of Arbitrators located in the State of California or (b) a retired California Superior Court or Appellate Court judge, and shall be conducted in accordance with the provisions of California Civil Procedure Code Sections 1280 et seq. as the exclusive remedy of such dispute; provided, however, that provisional injunctive relief may, but need not, be sought in a court of law while arbitration proceedings are pending, and any provisional injunctive relief granted by such court shall remain effective until the matter is finally determined by the Arbitrator. Final resolution of any dispute through arbitration may include any remedy or relief which the Arbitrator deems just and equitable. Any award or relief granted by the Arbitrator hereunder shall be final and binding

on the parties hereto and may be enforced by any court of competent jurisdiction. The parties acknowledge and agree that they are hereby waiving any rights to trial by jury in any action, proceeding or counterclaim brought by either of the parties against the other in connection with any matter whatsoever arising out of or in any way connected with this Agreement or Executive's employment.

23. ATTORNEYS' FEES

Executive and the Company agree that in any dispute resolution proceedings arising out of this Agreement, the prevailing party shall be entitled to its or his reasonable attorneys' fees and costs incurred by it or him in connection with resolution of the dispute in addition to any other relief granted.

24. SEVERABILITY

In the event that a court of competent jurisdiction determines that any portion of this Agreement is in violation of any statute or public policy, then only the portions of this Agreement which violate such statute or public policy shall be stricken, and all portions of this Agreement which do not violate any statute or public policy shall continue in full force and effect. Furthermore, any court order striking any portion of this Agreement shall modify the stricken terms as narrowly as possible to give as much effect as possible to the intentions of the parties under this Agreement.

25. NOTICES

All notices under this Agreement shall be in writing and shall be either personally delivered or mailed postage prepaid, by certified mail, return receipt requested:

(a) if to the Company:

Molina Healthcare, Inc.
Attention: J. Mario Molina, M.D., President and Chief Executive Officer
One Golden Shore Drive
Long Beach, California 90802

(b) if to Executive:

Dr. George Goldstein
19588 Mayfield Circle
Huntington Beach, CA 92648

Notice shall be effective when personally delivered, or five (5) business days after being so mailed, or when transmitted via facsimile with confirmation of receipt.

26. COUNTERPARTS

This Agreement may be executed in any number of counterparts, each of which shall be deemed an original and all of which together shall constitute one and the same instrument.

27. WITHHOLDING TAXES

The Company may withhold from any amounts payable under this Agreement such federal, state and local taxes as may be required to be withheld pursuant to any applicable law or regulation.

IN WITNESS WHEREOF, the Company and Executive have executed this Employment Agreement as of the date first above written.

"COMPANY"
Molina Healthcare, Inc.

By: /s/

J. Mario Molina, M.D.
Chairman, President, and Chief Executive Officer

"EXECUTIVE"
Dr. George Goldstein

/s/

Dr. George Goldstein

EXHIBIT 10.11

EMPLOYMENT AGREEMENT

This Employment Agreement (this "Agreement") is made as of January 1, 2002, between Mary Martha (Molina) Bernadett, MD, MBA ("Executive") and Molina Healthcare, Inc. (the "Company").

RECITALS

The Company desires to establish its right to the services of Executive in the capacities described below, on the terms and conditions hereinafter set forth, and Executive is willing to accept such employment on such terms and conditions. The parties hereto have previously entered into an Employment Agreement dated May 1, 1997 (the "Existing Agreement"), and this Agreement supercedes the Existing Agreement.

AGREEMENT

The parties agree as follows:

1. DUTIES

(a) The Company does hereby hire, engage, and employ Executive as Executive Vice President of the Company, and Executive does hereby accept and agree to such hiring, engagement, and employment. During the Period of Employment (as defined in Section 2), Executive shall serve the Company in such position in conformity with the provisions of this Agreement, directives of the Chief Executive Officer and the corporate policies of the Company as they presently exist, and as such policies may be amended, modified, changed, or adopted during the Period of Employment. Executive shall have duties and authority consistent with Executive's position as Executive Vice President and shall report to the Chief Executive Officer of the Company (the "Reporting Relationship").

(b) Throughout the Period of Employment, Executive shall devote his time, energy, and skill to the performance of his duties for the Company, vacations and other leave authorized under this Agreement excepted. Notwithstanding the foregoing, Executive shall be permitted to (i) engage in charitable and community affairs and (ii) make direct investments of any character in any non-competing business or businesses and to manage such investments (but not be involved in the day-to-day operations of any such business); provided, in each case, and in the aggregate, that such activities do not materially interfere with the performance of Executive's duties hereunder, and further provided that Executive may invest in a publicly traded competing business so long as such investment does not equal or exceed one percent of the outstanding shares of such publicly traded competing business.

(c) Executive hereby represents to the Company that the execution and delivery of this Agreement by Executive and the Company and the performance by Executive of Executive's duties hereunder shall not constitute a breach of, or otherwise contravene, the terms of any employment or other agreement or policy to which Executive is a party or otherwise bound.

2. PERIOD OF EMPLOYMENT

The "Period of Employment" shall, unless sooner terminated as provided herein, be a period commencing on January 1, 2002 (the "Effective Date") and ending with the close of business on December 31, 2002. Notwithstanding the preceding sentence, commencing with January 1, 2003 and on each January 1st thereafter (each an "Extension Date"), the Period of Employment shall be automatically extended for an additional one-year period so as to expire one year from such Extension Date, unless: (i) the Company or Executive provides the other party hereto ninety (90) days' prior written notice before the next scheduled Extension Date that the Period of Employment shall not be so extended (the "Non-Extension Notice"); or (ii) Executive is not less than sixty-five (65) years of age as of the next scheduled Extension Date. The term "Period of Employment" shall include any extension that becomes applicable pursuant to the preceding sentence.

3. COMPENSATION

(a) BASE SALARY. Executive's Base Salary shall be at a rate of not less than $300,000 annually ("Executive's Base Salary"), paid in accordance with regular payroll practices, but not less than monthly. The CEO shall review at least annually Executive's Base Salary for possible increase in accordance with the Company's customary review practices for its senior executives and may, in his sole discretion, periodically adjust Executive's Base Salary to reflect individual performance. In the event of an increase, Executive's Base Salary for the year in which the increase occurs shall be adjusted on a pro rata basis to reflect the increase.

(b) BONUS. Executive shall be eligible to earn an annual discretionary bonus for each fiscal year of the Company (an "Annual Bonus"), with a target Annual Bonus (the "Target Bonus") of thirty-three percent (33%) of his Base Salary, to be awarded at the sole discretion of the Compensation Committee based on the achievement of certain mutually agreed upon objectives. Executive shall be entitled to participate in all bonus or incentive plans applicable to the senior executives of the Company, including without limitation any Effective Option Plan (as defined in Section 4(e)). CEO may in his sole discretion, also award to Executive such extraordinary bonus(es) as CEO deems appropriate.

4. BENEFITS

(a) HEALTH AND WELFARE. During the Period of Employment, Executive shall be entitled to participate, on the same terms and at the same level as other executives, in all health and welfare benefit plans and programs generally available to other executives or employees of the Company (including, without limitation, the Company's medical, dental, vision, life benefits, life insurance, and long-term disability plans) as in effect from time to time and to receive any special benefits provided from time to time, subject to any legally required restrictions specified in such plans and programs. Without limiting the generality of the foregoing, Company shall provide life insurance for Executive, with Executive to designate the beneficiary thereunder, in an amount equal to Executive's base salary as in effect on the date of this Agreement and as in effect on the first business day of each calendar year thereafter.

(b) PAID TIME OFF AND OTHER LEAVE. During the Period of Employment, Executive shall receive 10.77 hours of paid time off per "pay period" of the Company (the "PTO"), subject to the Company's policies concerning accrual of PTO and provided that for any three hundred sixty five (365) day period within the Period of Employment Executive shall earn no less than a total of thirty five (35) days of PTO. Executive shall also be entitled to all other holiday and leave pay generally available to other executives of the Company.

(c) TRAVEL AND EXPENSE REIMBURSEMENTS. During the Period of Employment, Company will reimburse Executive for all reasonable expenses incurred in connection with performance of his duties under section 1 of this Agreement in accordance with the Company's expense reimbursement policies.

(d) RETIREMENT. During the Period of Employment, Executive shall be eligible to participate on the same terms and at the same level as other executives, in all retirement, 401(k), deferred compensation, or other savings plans generally available to other executives, or employees of the Company as in effect from time to time, subject to any legally required restrictions specified in such plans and programs.

(e) EQUITY GRANTS.

(i) Existing Options. Executive holds on the Effective Date options for zero shares of common stock of the Company (the "Existing Options") pursuant to an agreement entitled N/A, dated N/A. The Existing Options are subject to the terms and conditions of the Omnibus Stock and Incentive Plan (the "Option Plan"), and shall hereafter continue to be subject to and controlled by the terms and conditions of the Option Plan.

(ii) Initial Options. Executive shall, on the Effective Date, be granted stock options for zero (0) shares of the common stock of the Company (the "Initial Options") pursuant to an option agreement. The exercise price of the Initial Options will be $180 per share. The Initial Options are subject to the terms and conditions of the "Molina Healthcare, Inc. Amended and Restated Stock Incentive Plan" (the "Restated Option Plan").

(iii) Future Options. Executive shall be eligible, at the sole discretion of the Board, for additional annual stock option grants (the "Future Options") pursuant to one or more additional option agreements. Any Future Options will be granted under and subject to the terms and conditions of a stock option plan of the Company as then in effect (as of the date of any grant, an "Effective Option Plan"). The terms and conditions of such Future Options are intended to be such that Executive shall receive a compensation package commensurate with executives performing the same functions as Executives for businesses similar to the Company.

(f) OTHER BENEFITS. In addition to benefits specifically provided herein, during the Period of Employment, Executive shall be entitled to participate, on the same terms and at the same level as other executives, in all fringe benefit plans and perquisites provided by Company to its executives.

The employee benefits described in Sections 4(a) through (f) inclusive are referred to as "Executive Benefits."

5. DEATH OR DISABILITY

(a) PERMANENTLY DISABLED AND PERMANENT DISABILITY. The terms "Permanently Disabled" and "Permanent Disability" shall mean Executive's inability, because of physical or mental illness or injury, to perform the essential functions of his customary duties pursuant to this Agreement, with or without reasonable accommodation, and the continuation of such disabled condition for a period of twelve (12) months.

(b) TERMINATION DUE TO DEATH OR DISABILITY. If Executive dies or becomes Permanently Disabled during the Period of Employment, the Period of Employment and Executive's employment shall automatically cease and terminate as of the date of Executive's death or the date of Permanent Disability as determined by the Board (which date shall be referred to as the "Disability Date"), as the case may be. In the event of the termination of the Period of Employment and Executive's employment hereunder due to Executive's death or Permanent Disability, Executive or his estate shall be entitled to receive:

(i) Within five (5) business days, a lump sum cash payment equal to the sum of (x) any accrued but unpaid Base Salary and PTO as of the Termination Date hereunder and (y) any unpaid annual incentive compensation in respect of the most recently completed fiscal year preceding the Termination Date (the "Unpaid Annual Bonus"); and

(ii) Within thirty (30) days, such employee benefits described in Sections 4(a) and 4(c) through 4(f) inclusive, if any, as to which Executive may be entitled as of the Termination Date under the employee benefit plans and arrangements of the Company ((i) and (ii) collectively, the "Accrued Obligations").

6. TERMINATION BY THE COMPANY

(a) TERMINATION FOR CAUSE. The Company may terminate for Cause (as defined below) at any time the Period of Employment and Executive's employment hereunder by providing to Executive written notice of such termination ("Notice of Termination for Cause"). The term "Cause" shall mean a termination of service based upon a finding by the Company, acting in good faith and based on its reasonable belief at the time, that Executive:

(i) has engaged in unlawful acts involving moral turpitude or gross negligence with respect to the Company;

(ii) has consistently and willfully failed to perform his duties or has intentionally breached any material provision of any agreement with the Company or an affiliated entity; provided, however, that such failure or breach shall not constitute Cause unless it is (A) not reasonably curable or (B) if reasonably curable, is not cured by the Executive within thirty (30) days notice from the Company;

If the Executive's employment is terminated for Cause, the termination shall take effect on the Termination Date (as defined below). In the event of termination of the Period of Employment and Executive's employment hereunder due to a termination by the Company for Cause, Executive shall be entitled to receive the Accrued Obligations. All of the Accrued Obligations shall be paid on the Termination Date except those benefits described in Sections 4(a) and 4(c) through (f) inclusive, which shall be paid within thirty (30) days of the Termination Date.

If the Company attempts to terminate Executive's employment pursuant to this Section 6(a) and it is ultimately determined that the Company lacked Cause, the provisions of Section 6(b) ("Termination by the Company-Termination Without Cause") shall apply as if the Company had provided Executive with Notice of Termination Without Cause (as defined below) on the date the Company actually provided Executive with Notice of Termination for Cause.

(b) TERMINATION WITHOUT CAUSE. The Company may, without cause or reason, terminate at any time the Period of Employment and Executive's employment hereunder by providing Executive written notice of such termination ("Notice of Termination Without Cause"). A Non-Extension Notice by the Company shall be considered a termination without Cause. If Executive's employment is terminated without Cause, the termination shall take effect on the Termination Date. In the event of the termination of Executive's employment hereunder due to a termination by the Company without Cause (other than due to Executive's death or Permanent Disability):

(i) Executive shall be entitled to receive: (1) an amount equal to 100% of the sum of (x) Executive's Base Salary then in effect as of the Termination Date and (y) the Target Bonus for the fiscal year in which Executive's employment is terminated (the "Severance Payment"); (2) a pro rata portion of the Target Bonus for the fiscal year in which Executive's employment is terminated, based on the number of entire months of such fiscal year that have elapsed through the date of Executive's termination of employment as a fraction of twelve (12) (the "Pro Rata Bonus"); (3) the Accrued Obligations; (4) the entirety of Executive's contributions and the Company's contributions to Executive's 401(k) plan account as if Executive were fully vested as of the Termination Date, and (5) all other benefits under the welfare benefit and retirement plans contemplated by Sections 4(a) and 4(d) (the "Selected Benefits") until the earlier of (A) Executive's receipt of benefits substantially similar in scope and nature from another employer or (B) one year and one-half year after the Termination Date.

(ii) Executive shall be entitled to one hundred percent vesting of all of the options (including, without limitation, Existing Options, Initial Options, and Future Options) to purchase common stock of the Company ("Common Stock") held by Executive as of the Termination Date (the "Options").

(iii) Amounts payable under this Section 6(b) shall be payable as follows:

(A) amounts payable under clause (i) shall be, or shall commence to be, paid within 30 days following the Termination Date either in a single lump sum or in regular installments as a continuation of Executive's salary according to

the Company's customary payroll practices, as determined by the Executive in his sole discretion; provided however that any amounts representing accrued but unpaid Executive Base Salary, PTO an Unpaid Annual Bonus shall be paid on the Termination Date.

Executive shall have no duty to mitigate damages and none of the payments provided in this Section 6(b) shall be reduced by any amounts earned or received by Executive from a third party at any time.

7. TERMINATION BY EMPLOYEE

(a) TERMINATION WITHOUT GOOD REASON. Executive shall have the right to terminate the Period of Employment and Executive's employment hereunder at any time without Good Reason (as defined below) upon fifteen (15) days prior written notice of such termination to the Company. A Non-Extension Notice by Executive shall be considered a termination without Good Reason. Any such termination by Executive without Good Reason shall be treated for all purposes of this Agreement as a termination by the Company for Cause and the provisions of Section 6(a) shall apply, provided, however, that notwithstanding the foregoing, if Executive terminates the Period of Employment without Good Reason, Executive shall be allowed to exercise the Executive Put Option with respect to Executive Shares received pursuant to the exercise of Existing Options, subject to the terms and conditions generally applicable with respect to the Executive Put Option.

(b) TERMINATION WITH GOOD REASON. Executive may terminate the Period of Employment and resign from employment hereunder for "Good Reason." "Good Reason" shall mean (with or without regard to whether a Change in Control Event has occurred), without obtaining Executive's prior written consent thereto:

(i) a material and adverse change in Executive's position, duties, responsibilities, Reporting Relationship or status with the Company,

(ii) a change in Executive's office location to a point more than fifty (50) miles from Executive's current office,

(iii) the taking of any action by the Company to: (A) eliminate benefit plans applicable to Executive without providing substitutes which provide a substantially similar aggregate value of benefits, (B) materially reduce Executive's benefits thereunder or (C) substantially diminish the aggregate value to Executive of incentive awards or other fringe benefits, provided, however, that it shall not constitute Good Reason for the Company to, as part of an overall cost-reduction program, take any action described in (A) - (C) so long as such action is taken with respect to all senior executives and Executive is not disproportionately affected thereby,

(iv) any reduction in the Base Salary, provided, however, that it shall not constitute Good Reason for the Company to, as part of an overall cost-reduction program, reduce Executive's Base Salary so long as the base salaries of all other senior executives are simultaneously reduced by not less than the same percentage, or

(v) any breach of this Agreement by the Company or any successor thereto, including without limitation any failure by the Company to obtain the consent of any Successor Entity (as defined below) to the provisions contained in Section 9; provided, however, that none of the events described in clause (v) of this Section 7(b) shall constitute Good Reason unless Executive shall have notified the Company in writing describing the events which constitute Good Reason and then only if the Company shall have failed to cure such event within thirty (30) days after the Company's receipt of such written notice.

Any such termination by Executive for Good Reason shall be treated for all purposes of this Agreement as a termination by the Company without Cause and the provisions of Section 6(b) shall apply; provided, however, that if Executive attempts to resign for Good Reason pursuant to this Section 7(b) and it is ultimately determined that Good Reason did not exist, Executive shall be deemed to have resigned from employment without Good Reason and the provisions of Section 7(a) and, by reference therein, the provisions of Section 6(a), shall apply.

8. TERMINATION DATE

The term "Termination Date" shall mean (i) if Executive's employment is terminated by the Company for Cause, or by Executive for Good Reason, the effective date (pursuant to Section 25 ("Notices")) of written notice of such termination to Executive or to the Company, as the case may be; (ii) if Executive's employment is terminated by the Company other than for Cause or Disability, the date on which the Company notifies Executive of such termination; or (iii) if Executive's employment is terminated by reason of Death or Disability, the Disability Date.

9. CHANGE IN CONTROL

(a) Notwithstanding anything to the contrary in this Agreement, if a Change in Control Event (as defined below) of the Company occurs during the term of this Agreement, and if within two years following such Change in Control Event either (1) the Company terminates Executive's employment without Cause or (2) Executive terminates his employment for Good Reason:

(i) the Company shall pay to Executive an amount equal to the sum of (w) two times the Severance Payment, (x) the Pro Rata Bonus, (y) the Accrued Obligations and (z) the entirety of Executive's contributions and the Company's contributions to Executive's 401(k) plan account as if Executive were fully vested as of the Termination Date, such amount to be, or to commence to be, paid on the Termination Date either in a single lump sum or in regular installments as a continuation of Executive's salary according to the Company's customary payroll practices, as determined by the Executive in his sole discretion at the time of termination. This payment shall be in lieu of the payment otherwise payable under clause (i) of Section 6(b).

(ii) the Company shall continue to provide the Selected Benefits until the earlier of (x) Executive's receipt of benefits substantially similar in scope and nature from another employer or (y) three years after the Termination Date.

(iii) and, regardless of whether any of the Options have been assumed by any Successor Entity, the provisions of clauses (ii) and (iii) of Section 6(b) will apply.

(b) A "Change in Control Event" shall mean any of the following:

(i) Approval by the Board and by shareholders of the Company (or, if no shareholder approval is required, by the Board alone) of the dissolution or liquidation of the Company, other than in the context of a transaction that does not constitute a Change in Control Event under clause (ii) below;

(ii) Consummation of a merger, consolidation, or other reorganization, with or into, or the sale of all or substantially all of the Company's business and/or assets as an entirety to, one or more entities that are not Subsidiaries or other affiliates of the Company (a "Business Combination"), unless (1) as a result of the Business Combination, more than fifty percent (50%) of the outstanding voting power generally in the election of directors of the surviving or resulting entity or a parent thereof (the "Successor Entity") immediately after the reorganization is, or will be, owned, directly or indirectly, by holders of the Company's voting securities immediately before the Business Combination; and (2) no "person" (as such term is used in Sections 13(d) and 14(d) of the Exchange Act), excluding the Successor Entity or an Excluded Person, beneficially owns, directly or indirectly, more than fifty percent (50%) of the outstanding shares or the combined voting power of the outstanding voting securities of the Successor Entity, after giving effect to the Business Combination, except to the extent that such ownership existed prior to the Business Combination; or

(iii) Any "person" (as such term is used in Sections 13(d) and 14(d) of the Exchange Act) other than an Excluded Person: (a) becomes the beneficial owner (as defined in Rule 13d-3 under the Exchange Act), directly or indirectly, of securities of the Company representing more than fifty percent (50%) of the combined voting power of the Company's then outstanding securities entitled to then vote generally in the election of directors (the "Voting Power") of the Company (a "Majority Holder"), other than as result of (1) an acquisition directly from the Company, (2) an acquisition by the Company, or (3) an acquisition by an entity pursuant to a transaction which is expressly excluded under clause (ii) above (an "Excluded Transaction"); or (b) provided that the beneficial owner of a majority of the Voting Power as of the Effective Date is no longer a Majority Holder, becomes the beneficial owner (as defined in Rule 13d-3 under the Exchange Act), directly or indirectly, of securities of the Company representing more than thirty percent (30%) of the Voting Power, other than as a result of an Excluded Transaction.

(iv) For the purposes of this Section 9(c):

(A) "Exchange Act" shall mean the Securities Exchange Act of 1934, as amended from time to time.

(B) "Excluded Person" shall mean (a) any person described in and satisfying the conditions of Rule 13d-1(b)(1) under the Exchange Act, (b) the Company, (c) an employee benefit plan (or related trust) sponsored or maintained by the Company or the Successor Entity, or (d) any person who is the beneficial owner (as defined in Rule 13d-3 under the Exchange Act) of more than [25%] of the Common Stock on the Effective Date (or an affiliate, successor, heir, descendant, or related party of or to such person).

(C) "Subsidiary" shall mean any corporation or other entity a majority of whose outstanding voting stock or voting power is beneficially owned, directly or indirectly, by the Company.

(c) Executive shall have no duty to mitigate damages and none of the payments provided in this Section 9 shall be reduced by any amounts earned or received by Executive from a third party at any time. Notwithstanding anything to the contrary in this Section 9, if, in connection with a Change in Control Event, Executive voluntarily enters a new written employment agreement with the Company or the Successor Entity, Executive may no longer rely upon the provisions of this Section 9.

10. CONFIDENTIALITY

Executive will not at any time (whether during or after his employment with the Company), unless compelled by lawful process, disclose or use for his own benefit or purposes or the benefit or purposes of any other person, firm, partnership, joint venture, association, corporation or other business organization, entity or enterprise other than the Company and any of its subsidiaries or affiliates, any trade secrets, or other confidential data or information relating to customers, development programs, costs, marketing, trading, investment, sales activities, promotion, credit and financial data, financing methods, or plans of the Company or of any subsidiary or affiliate of the Company; provided that the foregoing shall not apply to information which is not unique to the Company or which is generally known to the industry or the public other than as a result of Executive's breach of this covenant. Executive agrees that upon termination of his employment with the Company for any reason, he will return to the Company immediately all memoranda, books, papers, plans, information, letters and other data, and all copies thereof or therefrom, in any way relating to the business of the Company and its affiliates, except that he may retain personal notes, notebooks and diaries that do not contain confidential information of the type described in the preceding sentence. Executive further agrees that he will not retain or use for his account at any time any trade names, trademark or other proprietary business designation used or owned in connection with the business of the Company or its affiliates.

11. NON-SOLICITATION AND NON-DISPARAGEMENT

During the Period of Employment and for a period of eighteen (18) months thereafter, Executive will not, directly or indirectly: (a) solicit or attempt to solicit any employee of the Company to terminate his or her relationship with the Company in order to become an employee, consultant or independent contractor to or for any other person or business entity; (b) solicit customers, suppliers or clients of the Company to reduce or discontinue their business with the

Company or to engage in business with any competing entity; (c) disparage the Company, its business, or its reputation; or (d) otherwise disrupt or interfere with business relationships (whether formed before or after the date of this Agreement) between the Company or any of its affiliates and customers, suppliers, partners, members or investors of the Company or its affiliates.

12. RELEASE REQUIRED FOR SEVERANCE PAYMENTS

Notwithstanding anything to the contrary in this Agreement, as a condition precedent to the receipt of any payment under Section 6, Section 7, or Section 9 of this Agreement pursuant to Executive's termination of employment with the Company, Executive shall be required to execute a general waiver and release agreement, in form drafted by and satisfactory to the Company, providing for the complete waiver, release, and discharge of all known and unknown present and future claims against the Company.

13. SECTION 280G

(a) SHAREHOLDER APPROVAL REQUIRED.

Notwithstanding anything to the contrary in this Agreement, Section 13 of this Agreement shall not become effective in any part unless and until it is fully disclosed to and approved by a vote of the persons who own more than seventy five percent (75%) of the voting power of all outstanding capital stock of the Company.

(b) GROSS-UP.

(i) Gross-Up Payment. If, notwithstanding clause (a) above, it is determined (pursuant to Section 13(b)(ii)) or finally determined (as defined in Section 13(b)(iii)) that any payment, distribution, transfer, or benefit by the Company or a direct or indirect subsidiary or affiliate of the Company, to or for the benefit of Executive or Executive's dependents, heirs or beneficiaries (whether such payment, distribution, transfer, benefit or other event occurs pursuant to the terms of this Agreement or otherwise, but determined without regard to any additional payments required under this Section 13(b)) (each a "Payment" and collectively the "Payments") is subject to the excise tax imposed by Section 4999 of the Code, and any successor provision or any comparable provision of state or local income tax law (collectively, "Section 4999"), or any interest, penalty or addition to tax is incurred by Executive with respect to such excise tax (such excise tax, together with any such interest, penalty, and addition to tax, hereinafter collectively referred to as the "Excise Tax"), then, within ten (10) days after such determination or final determination, as the case may be, the Company shall pay to Executive (or to the applicable taxing authority on Executive's behalf) an additional cash payment (hereinafter referred to as the "Gross-Up Payment") equal to an amount such that after payment by Executive of all taxes, interest, penalties, additions to tax and costs imposed or incurred with respect to the Gross-Up Payment (including, without limitation, any income and excise taxes imposed upon the Gross-Up Payment), Executive retains an amount of the Gross-Up Payment equal to the Excise Tax imposed upon such Payment or Payments. This provision is intended to put Executive in the same position as Executive would have been had no Excise Tax been imposed upon or incurred as a result of any Payment.

(ii) Determination of Gross-Up.

(A) Except as provided in Section 13(b)(iii), the determination that a Payment is subject to an Excise Tax shall be made in writing by the principal certified public accounting firm then retained by the Company to audit its annual financial statements (the "Accounting Firm"). Such determination shall include the amount of the Gross-Up Payment and detailed computations thereof, including any assumptions used in such computations. Any determination by the Accounting Firm will be binding on the Company and Executive.

(B) For purposes of determining the amount of the Gross-Up Payment, Executive shall be deemed to pay Federal income taxes at the highest marginal rate of Federal income taxation in the calendar year in which the Gross-Up Payment is to be made. Such highest marginal rate shall take into account the loss of itemized deductions by Executive and shall also include Executive's share of the hospital insurance portion of FICA and state and local income taxes at the highest marginal rate of taxation in the state and locality of Executive's residence on the date of his or her Qualifying Termination Event, net of the maximum reduction in Federal income taxes that could be obtained from the deduction of such state and local taxes.

(iii) Notification.

(A) Executive shall notify the Company in writing of any claim by the Internal Revenue Service (or any successor thereof) or any state or local taxing authority (individually or collectively, the "Taxing Authority") that, if successful, would require the payment by the Company of a Gross-Up Payment. Such notification shall be given as soon as practicable but no later than thirty (30) days after Executive receives written notice of such claim and shall apprise the Company of the nature of such claim and the date on which such claim is requested to be paid; provided, however, that failure by Executive to give such notice within such thirty (30) day period shall not result in a waiver or forfeiture of any of Executive's rights under this Section 13(b) except to the extent of actual damages suffered by the Company as a result of such failure. Executive shall not pay such claim prior to the expiration of the fifteen (15) day period following the date on which Executive gives such notice to the Company (or such shorter period ending on the date that any payment of taxes, interest, penalties or additions to tax with respect to such claim is due). If the Company notifies Executive in writing prior to the expiration of such fifteen (15) day period (regardless of whether such claim was earlier paid as contemplated by the preceding parenthetical) that it desires to contest such claim, Executive shall:

(1) give the Company any information reasonably requested by the Company relating to such claim;

(2) take such action in connection with contesting such claim as the Company shall reasonably request in writing from time to

time, including, without limitation, accepting legal representation with respect to such claim by an attorney selected by the Company;

(3) cooperate with the Company in good faith in order effectively to contest such claim; and

(4) permit the Company to participate in any proceedings relating to such claim;

provided, however, that the Company shall bear and pay directly all attorneys fees, costs and expenses (including additional interest, penalties and additions to tax) incurred in connection with such contest and shall indemnify and hold Executive harmless, on an after-tax basis, for all taxes (including, without limitation, income and excise taxes), interest, penalties and additions to tax imposed in relation to such claim and in relation to the payment of such costs and expenses or indemnification.

(B) Without limitation on the foregoing provisions of this Section 13(b)(iii), and to the extent its actions do not unreasonably interfere with or prejudice Executive's disputes with the Taxing Authority as to other issues, the Company shall control all proceedings taken in connection with such contest and, in its or their reasonable discretion, may pursue or forego any and all administrative appeals, proceedings, hearings and conferences with the Taxing Authority in respect of such claim and may, at its or in their sole option, either direct Executive to pay the tax, interest or penalties claimed and sue for a refund or contest the claim in any permissible manner, and Executive agrees to prosecute such contest to a determination before any administrative tribunal, in a court of initial jurisdiction and in one or more appellate courts, as the Company shall determine; provided, however, that if the Company directs Executive to pay such claim and sue for a refund, the Company shall advance an amount equal to such payment to Executive, on an interest-free basis, and shall indemnify and hold Executive harmless, on an after-tax basis, from all taxes (including, without limitation, income and excise taxes), interest, penalties and additions to tax imposed with respect to such advance or with respect to any imputed income with respect to such advance, as any such amounts are incurred; and, further, provided, that any extension of the statute of limitations relating to payment of taxes, interest, penalties or additions to tax for the taxable year of Executive with respect to which such contested amount is claimed to be due is limited solely to such contested amount; and, provided, further, that any settlement of any claim shall be reasonably acceptable to Executive, and the Company's control of the contest shall be limited to issues with respect to which a Gross-Up Payment would be payable hereunder, and Executive shall be entitled to settle or contest, as the case may be, any other issue.

(C) If, after receipt by Executive of an amount advanced by the Company pursuant to Section 13(b)(iii)(A), Executive receives any refund with

respect to such claim, Executive shall (subject to the Company's complying with the requirements of this Section 13(b)) promptly pay to the Company an amount equal to such refund (together with any interest paid or credited thereof after taxes applicable thereto), net of any taxes (including, without limitation, any income or excise taxes), interest, penalties or additions to tax and any other costs incurred by Executive in connection with such advance, after giving effect to such repayment. If, after the receipt by Executive of an amount advanced by the Company pursuant to Section 13(b)(iii)(A), it is finally determined that Executive is not entitled to any refund with respect to such claim, then such advance shall be forgiven and shall not be required to be repaid and the amount of such advance shall be treated as a Gross-Up Payment and shall offset, to the extent thereof, the amount of any Gross-Up Payment otherwise required to be paid.

(D) For purposes of this Section 13(b), whether the Excise Tax is applicable to a Payment shall be deemed to be "finally determined" upon the earliest of: (1) the expiration of the fifteen (15) day period referred to in Section 13(b)(iii)(A) if the Company or Executive's Company has not notified Executive that it intends to contest the underlying claim, (2) the expiration of any period following which no right of appeal exists, (3) the date upon which a closing agreement or similar agreement with respect to the claim is executed by Executive and the Taxing Authority (which agreement may be executed only in compliance with this section), or (4) the receipt by Executive of notice from the Company that it no longer seeks to pursue a contest (which shall be deemed received if the Company does not, within fifteen (15) days following receipt of a written inquiry from Executive, affirmatively indicate in writing to Executive that the Company intends to continue to pursue such contest).

It is possible that no Gross-Up Payment will initially be made but that a Gross-Up Payment should have been made, or that a Gross-Up Payment will initially be made in an amount that is less than what should have been made (either of such events is referred to as an "Underpayment"). It is also possible that a Gross-Up Payment will initially be made in an amount that is greater than what should have been made (an "Overpayment"). The determination of any Underpayment or Overpayment shall be made by the Accounting Firm in accordance with Section 13(b)(ii). In the event of an Underpayment, the amount of any such Underpayment shall be paid to Executive as an additional Gross-Up Payment. In the event of an Overpayment, any such Overpayment shall be treated for all purposes as a loan to Executive with interest at the applicable Federal rate provided for in Section 1274(d) of the Code. In such case, the amount of the loan shall be subject to reduction to the extent necessary to put Executive in the same after-tax position as if such Overpayment were never made. The amount of any such reduction to the loan shall be determined by the Accounting Firm in accordance with the principles set forth in Section 13(b)(ii). Executive shall repay the amount of the loan (after reduction, if any) to the Company as soon as administratively practicable after the Company notifies Executive of (x) the Accounting Firm's determination that an Overpayment was made and (y) the amount to be repaid.

14. CONTRACT REIMBURSEMENT

The Company shall reimburse Executive on a fully grossed-up, after-tax basis or directly pay for all reasonable legal fees and costs attributed to the development, reviews and modifications of this Agreement and associated legal services. Such fees and costs shall not exceed two thousand five hundred dollars ($2,500). This Section 14 shall not be deemed to limit any of Executive's rights under Section 23 ("Attorneys' Fees").

15. ASSIGNMENT

This Agreement is personal in its nature and neither of the parties hereto shall, without the consent of the other, assign or transfer this Agreement or any rights or obligations hereunder; provided, however, that, in the event of a merger, consolidation, or transfer or sale of all or substantially all of the assets of the Company with or to any other individual(s) or entity, this Agreement shall, subject to the provisions hereof, be binding upon and inure to the benefit of such successor and such successor shall discharge and perform all the promises, covenants, duties, and obligations of the Company hereunder.

16. GOVERNING LAW

This Agreement and the legal relations hereby created between the parties hereto shall be governed by and construed under and in accordance with the internal laws of the State of California, without regard to conflicts of laws principles thereof.

17. ENTIRE AGREEMENT

This Agreement embodies the entire agreement of the parties hereto respecting the matters within its scope. This Agreement supersedes all prior agreements of the parties hereto on the subject matter hereof. Any prior negotiations, correspondence, agreements, proposals, or understandings relating to the subject matter hereof shall be deemed to be merged into this Agreement and to the extent inconsistent herewith, such negotiations, correspondence, agreements, proposals, or understandings shall be deemed to be of no force or effect. There are no representations, warranties, or agreements, whether express or implied, or oral or written, with respect to the subject matter hereof, except as set forth herein.

18. MODIFICATIONS

This Agreement shall not be modified by any oral agreement, either express or implied, and all modifications hereof shall be in writing and signed by the parties hereto.

19. WAIVER

Failure to insist upon strict compliance with any of the terms, covenants, or conditions hereof shall not be deemed a waiver of such term, covenant, or condition, nor shall any waiver or relinquishment of, or failure to insist upon strict compliance with, any right or power hereunder at any one or more times be deemed a waiver or relinquishment of such right or power at any other time or times.

20. NUMBER AND GENDER

Where the context requires, the singular shall include the plural, the plural shall include the singular, and any gender shall include all other genders.

21. SECTION HEADINGS

The section headings in this Agreement are for the purpose of convenience only and shall not limit or otherwise affect any of the terms hereof.

22. ARBITRATION

Any controversy arising out of or relating to Executive's employment, this Agreement, its enforcement or interpretation, or because of an alleged breach, default, or misrepresentation in connection with any of its provisions, shall be submitted to arbitration in Los Angeles County, California, before a sole arbitrator who is either (a) a member of the National Academy of Arbitrators located in the State of California or (b) a retired California Superior Court or Appellate Court judge, and shall be conducted in accordance with the provisions of California Civil Procedure Code Sections 1280 et seq. as the exclusive remedy of such dispute; provided, however, that provisional injunctive relief may, but need not, be sought in a court of law while arbitration proceedings are pending, and any provisional injunctive relief granted by such court shall remain effective until the matter is finally determined by the Arbitrator. Final resolution of any dispute through arbitration may include any remedy or relief which the Arbitrator deems just and equitable. Any award or relief granted by the Arbitrator hereunder shall be final and binding on the parties hereto and may be enforced by any court of competent jurisdiction. The parties acknowledge and agree that they are hereby waiving any rights to trial by jury in any action, proceeding or counterclaim brought by either of the parties against the other in connection with any matter whatsoever arising out of or in any way connected with this Agreement or Executive's employment.

23. ATTORNEYS' FEES

Executive and the Company agree that in any dispute resolution proceedings arising out of this Agreement, the prevailing party shall be entitled to its or his reasonable attorneys' fees and costs incurred by it or him in connection with resolution of the dispute in addition to any other relief granted.

24. SEVERABILITY

In the event that a court of competent jurisdiction determines that any portion of this Agreement is in violation of any statute or public policy, then only the portions of this Agreement which violate such statute or public policy shall be stricken, and all portions of this Agreement which do not violate any statute or public policy shall continue in full force and effect. Furthermore, any court order striking any portion of this Agreement shall modify the stricken terms as narrowly as possible to give as much effect as possible to the intentions of the parties under this Agreement.

25. NOTICES

All notices under this Agreement shall be in writing and shall be either personally delivered or mailed postage prepaid, by certified mail, return receipt requested:

(a) if to the Company:

Molina Healthcare, Inc.
Attention: J. Mario Molina, M.D., President and Chief Executive Officer
One Golden Shore Drive
Long Beach, California 90802

(b) if to Executive:

Mary Martha (Molina) Bernadett, MD, MBA
701 Pepper Tree Lane
Long Beach, CA 90815

Notice shall be effective when personally delivered, or five (5) business days after being so mailed, or when transmitted via facsimile with confirmation of receipt.

26. COUNTERPARTS

This Agreement may be executed in any number of counterparts, each of which shall be deemed an original and all of which together shall constitute one and the same instrument.

27. WITHHOLDING TAXES

The Company may withhold from any amounts payable under this Agreement such federal, state and local taxes as may be required to be withheld pursuant to any applicable law or regulation.

IN WITNESS WHEREOF, the Company and Executive have executed this Employment Agreement as of the date first above written.

"COMPANY"
Molina Healthcare, Inc.

By: /s/

J. Mario Molina, M.D.
Chairman, President, and Chief Executive Officer

"EXECUTIVE"
Mary Martha (Molina) Bernadett, MD, MBA

/s/

Mary Martha (Molina) Bernadett, MD, MBA

EXHIBIT 10.12

OMNIBUS STOCK AND INCENTIVE PLAN

MOLINA HEALTHCARE, INC.

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OMNIBUS STOCK AND INCENTIVE PLAN
MOLINA HEALTHCARE, INC.

SECTION 1. Establishment. There is hereby established the Omnibus Stock and Incentive Plan (the "Plan"), pursuant to which key employees of Molina Healthcare, Inc., a California corporation ("MHI") and its wholly owned subsidiaries, may be permitted to participate in the increases in value of MHI and its wholly owned subsidiaries (collectively, the "Employers").

SECTION 2. Purpose of Plan. Under this Plan, MHI may grant any one or more type of incentive awards to professional and managerial employees who measurably impact the performance of the Employers.

SECTION 3. Types of Awards Under Plan. MHI may grant under this Plan Qualified and Non-Qualified Stock Options (as described in Section 7) ("Options"), Stock Appreciation Rights (as described in Section 8) ("SARs"), Performance Units (as described in Section 9)("Performance Units"), Performance Shares (as described in Section 9)("Performance Shares"), Restricted Stock ("Restricted Stock"), Restricted Stock Units ("Restricted Stock Units") and grants of stock not subject to restrictions ("Unrestricted Stock Grants") (as described in Section 10). Options, SARs, Performance Units, Performance Shares, Restricted Stock Units, Unrestricted Stock Grants and Restricted Stock are collectively referred to herein as "Awards".

SECTION 4. Eligibility. The Committee may grant Awards to any employees (including officers) of the Employers. Any employee to whom the Committee has granted an Award ("Participant") shall be bound by the terms of this Plan and the Stock Option Agreement, Stock Appreciation Right Agreement, Performance Agreement and/or Restricted Stock Agreement (collectively, the "Award Agreement") applicable to him.

SECTION 5. Number of Shares Covered By Options and Restricted Stock Grants; No Preemptive Rights; Right of First Refusal. The total number of shares that may be awarded under this Plan shall be that number of shares that is equal to six point eight percent (6.8%) of the issued and outstanding shares of common stock as of the first day of each calendar year for which the Plan is in effect ("Common Stock") (or the number and kind of shares of common stock of MHI or other securities of MHI which, in accordance with Section 11 of the Plan, shall be substituted for such shares of Common Stock or to which

said shares shall be adjusted; hereinafter, all references to Common Stock includes references to said shares to which said shares are adjusted). The issuance of Common Stock pursuant to the provisions of this Plan for Awards shall be free from any preemptive or preferential right of subscription or purchase on the part of any stockholder, If any outstanding Option or grant of Restricted Stock granted under this Plan expires or is terminated for any reason, the shares of Common Stock subject to the unexercised portion of such Option or grant of Restricted Stock will again be available for Options and grants of Restricted Stock issued under this Plan.

Each certificate for Common Stock of MHI issued under the Plan shall be endorsed with the following legend:

> "This certificate shall not be transferred except in accordance with the provisions of a Right of First Refusal as set forth in Section 5 of Molina Healthcare, Inc.'s Omnibus Stock and Incentive Plan, a copy of which is on file in the office of Molina Healthcare, Inc., and the provisions of said Right of First Refusal shall be binding upon this certificate and each holder hereof."

A Participant desiring to sell Common Stock of MHI issued pursuant to this Plan shall give notice in writing of his desire to MHI. MHI thereupon shall have the option to purchase Common Stock in exchange for the Fair Market Value as determined under Section 7. Such option shall be exercised by written notice to the Participant within thirty (30) days after receipt of his notice of desire to sell stock that MHI agrees to purchase said Common Stock. Payment for such Common Stock shall be made within one year of MHI's written notification of its exercise of its right to purchase the common stock, with interest of eight percent (8%) per annum, simple interest, accruing from the date of notice of exercise of MHI's right to repurchase. Payment shall be made, at Molina Healthcare's discretion, in either a) a lump sum, or b) multiple approximately equal installments.

SECTION 6. Administration.

(a) This Plan shall be administered by the committee (the "Committee") referred to in paragraph (b) of this Section. Subject to the express provisions of this Plan, the Committee shall have complete authority, in its discretion,

(i) to interpret this Plan, to prescribe, amend and rescind rules and regulations relating to the Plan;

(ii) to determine the terms and provisions of Awards granted hereunder and to make such determinations as to the Participants to receive Awards, the form, amount and timing of such Awards, the terms and provisions of such Awards, and the Agreements evidencing the same, which need not be uniform and which the Committee may make selectively among Participants who receive, or who are to receive, Awards under the Plan, whether or not the Participants are similarly situated;

(iii) to determine to whom the Options shall be granted, the times and the prices at which Options are granted, the Option periods, the number of shares of Common Stock to be subject to each Option, whether each Option shall be an Incentive Stock Option or a Non-Incentive Stock Option, and to determine the terms and provisions of each Option (which need not be identical);

(iv) to determine to whom SARS shall be granted, the times and duration of each SAR, the number of shares of Common Stock to which each SAR relates, whether an SAR is granted with respect to Options or alone, without reference to any related stock option, and to determine the terms and provisions of each SAR (which need not be identical);

(v) to determine to whom Performance Shares and Performance Units shall be granted, the applicable Performance Period (as that term is defined in Section 9), and the number of shares of Common Stock represented by Performance Shares and Performance Units ("Performance Awards"), to maintain Performance Accounts (as defined in Section 9), and to determine the terms and provisions of Performance Awards (which need not be identical);

(vi) to determine to whom Restricted Stock, Unrestricted Stock and Restricted Stock Units shall be granted, the Restriction Period (as that term is defined in Section 10), the number of shares of Restricted Stock, the terms and provisions (which

need not be identical) of awards of Restricted Stock and Restricted Stock Units and whether the Participant has met the goals on or before the close of the Restriction Period;

(vii) to impose such limitations with respect to Options and Restricted Stock, including without limitation, any relating to the application of federal or state securities laws, as the Committee may deem necessary or desirable;

(viii) to determine the dates of employment of any employee of the Employers, and the reasons for termination of any Participant;

(ix) to determine whether any leave of absence constitutes a termination of employment for purposes of this Plan and the impact, if any, of such leave of absence on awards theretofore made under this Plan;

(x) to determine when a person's change of status with respect to the Employers constitutes a termination of such person's employment for purposes of this Plan;

(xi) to make such determinations as it deems equitable with respect to the impact, if any, of leaves of absence from the Employers upon Awards hereunder;

(xii) to grant dividend equivalents upon Awards (other than Restricted Stock, for which Participants are entitled to receive dividends and other distributions paid with respect to Common Shares so held), provided that any such dividend equivalents shall be subject to the terms and conditions imposed by the Committee; and

(xiii) to make all other determinations necessary or advisable for, the administration of the Plan.

In making determinations under this Section 6, the Committee may take into account the nature of the services rendered by the respective employees, their present and potential contributions to the success of the

Employers and such other factors as the Committee, in its discretion, deems relevant. The Committee's determination on all of the matters referred to in this Section 6 shall be conclusive,

(b) The Committee shall consist of from two (2) to five (5) individuals who may, but need not, be members of the Board of Directors of MHI; provided, however, all of the functions of the Committee may be performed, and the powers and authority of the Committee exercised, by the Board of Directors of MHI, in which event the term "Committee" in this Plan, or in any agreement entered into under this Plan with respect to an Award, shall mean the Board of Directors of MHI. The Committee shall be appointed by the Board, which may at any time and from time to time, remove any member of the Committee, with or without cause, appoint additional members to the Committee and fill vacancies, however caused, in the Committee. A majority of members of the Committee shall constitute a quorum. All determinations of the Committee shall be made by a majority of its members. Any decision or determination of the Committee reduced to writing and signed by all of the members of the Committee shall be fully effective as if it had been made at a meeting duly called and held.

(c) Nothing contained in this Plan shall be deemed to give any individual any right to be granted an Award except to the extent and upon such terms and conditions as may be determined by the Committee.

(d) The Committee may at its election provide in any Agreement relating to an Award under this Plan that an Employer will loan to the holder thereof an amount not greater than the excess of (i) the purchase price of the shares of Common Stock or other securities issuable upon exercise over (ii) the par value of such shares of Common Stock or other securities. Any such loan will be on the terms and conditions the Committee deems appropriate.

SECTION 7. Terms of Stock Options. Each Option granted under this Plan shall be evidenced by a written agreement (the "Stock Option Agreement") which shall be executed by MHI and by the Participant, and shall be subject to the following terms and conditions:

(a) The price at which shares of Common Stock covered by each Option may be purchased pursuant thereto shall be determined in each case on the date of grant by the Committee, but shall be an amount not less than the par value of the shares and, for Options that are intended to qualify as Incentive Stock Options pursuant to Code Section 422, not less than the Fair Market Value of the shares of Common Stock at the time the Option is granted. For purposes of this Section, the Fair Market Value of shares of Common Stock on any day shall be:

(i) in the event the Common Stock is not publicly traded, the fair market value as of the regularly performed valuation (or special valuation date as specified by the Committee ("Valuation Date") as determined in good faith in an outside appraisal by an accounting firm or certified valuation specialist selected by MHI in its discretion; or

(ii) in the event the Common Stock is publicly traded, the last sale price of a share of Common Stock as reported by the principal quotation service on which the Common Stock is listed, or, if the last sale prices are not reported with respect to the Common Stock, the mean of the high bid and low asked price of a share of Common Stock as reported by such principal quotation service, or, if there is no such report by such quotation service, for such day, such fair market value shall be the average of (A) the last sale price (or, if last sale prices are not reported with respect to the Common Stock, the mean of the high bid and low asked prices) on the day next preceding such day for which there was a report, and (B) the last sale price (or if last sale prices are not reported with respect to the Common Stock, the mean of the high bid and low asked prices) on the day next succeeding such day for which there was a report, or as otherwise determined by the Committee in its discretion pursuant to any reasonable method contemplated by Section 422 of the Code and any Treasury regulations issued pursuant to that Section.

(b) The option price of the shares to be purchased pursuant to each Option shall be paid in full in cash or, in the discretion of the

Committee, by delivery (i.e. surrender) of shares of Common Stock of MHI which have been owned by the Participant for at least six months prior to the exercise of the Option (provided that such shares are not the subject of any pledge or security interest). Shares of Common Stock so delivered will be valued on the day of delivery for the purpose of determining the extent to which the option price has been paid thereby, in the same manner as provided for in the determination of Fair Market Value as set forth in paragraph (a) of this Section, or as otherwise determined by the Committee in its discretion pursuant to any reasonable method contemplated by Section 422 of the Code and any Treasury regulations issued pursuant to that Section.

(c) Each Stock Option Agreement shall provide that such Option may be exercised by the Participant, in such parts and at such times, as may be specified in such Stock Option Agreement, within a period ending not later than ten years after the date on which the Option is granted (the "Option Period"); provided, however, that the Option Period shall end on the earlier of the date specified in such Stock Option Agreement or the date established below:

(i) Options may be exercised only

(A) During the continuance of the Participant's employment; or

(B) If the Participant terminates employment other than by retirement under (D) below or for Cause, during the period ending ninety (90) days after the date of termination of such employment to the extent that the right to exercise such Options had accrued on or before the date of termination.

(C) In the case of a grant of an Option to an officer or director (as those terms are used in Rule 16a-1 promulgated under the Securities Exchange Act of 1934 or any similar rule which may subsequently be in effect (an "Officer")) the Committee may determine (i) no such Option may be exercised during the first six (6)

months of its term, or (ii) if such Option is exercisable during the first six (6) months of its term, no Common Stock acquired on such exercise shall be transferable until the date which is six (6) months following of the date of grant of the Option. Each Option which is intended to qualify as an Incentive Stock Option pursuant to Section 422 of the Code and each Option which is intended to qualify as another type of incentive stock option which may subsequently be authorized by law, shall comply with the applicable provisions of the Code pertaining to such options.

(D) If the Participant terminates employment and the Committee determines that the termination occurs because of the Participant's retirement or disability, the Participant may exercise the Option if such exercise occurs before the first to occur of anniversary of (i) the Participant's retirement or disability, or (ii) the expiration of the Option Period.

(E) If the Participant dies within the Option Period, the Options may be exercised, to the extent specified in the Stock Option Agreement and as herein provided, by the person or persons entitled to do so under the Participant's will, or, if the Participant fails to make testamentary disposition of said Options, or dies intestate, by the Participant's legal representative or representatives, but only if such exercise occurs before the first to occur of (i) the expiration of the Option Period; or (ii) the first anniversary of the Participant's death.

(F) A termination shall be for Cause by reason of any of the following: (i) the Participant's conviction of, or plea of nolo contendere to, any felony or to any crime or offense causing harm to any Employer or an employee (whether or not for personal gain) or involving acts of moral turpitude, (ii) the Participant's repeated intoxication by alcohol or drugs during the

performance of his duties, (iii) malfeasance in the conduct of the Participant's duties involving misuse or diversion of any Employer's or an employee's funds, embezzlement or willful and material misrepresentations or concealments on any written reports submitted to any Employer, (iv) repeated material failure by the Participant to perform the duties of his employment; (v) material failure by the Participant to follow or comply with the reasonable and lawful written directives of any Employer or the Participant's immediate supervisor; or (vi) a material breach by the Participant of any written agreement between the Participant and any Employer, including without limitation any breach of any written non competition covenant or written covenant by the Participant with respect to the non-disclosure of confidential information.

(d) In the discretion of the Committee, a single Stock Option Agreement may include both Incentive Stock Options and Non-Incentive Stock Options, or separate Stock Option Agreements may be set forth for Incentive Stock Options and Non-Incentive Stock Options.

(e) Each Option granted under this Plan shall be non-transferable, and its terms shall state that it is non-transferable and shall, during the lifetime of the Participant be exercisable only by the Participant; notwithstanding the foregoing, Options shall be transferable by the laws of descent and distribution. However, a Participant may hold a Non-Incentive Stock Option in a trust, provided that the Committee may require that the optionee submit an opinion of his legal counsel, satisfactory to the Committee, that such holding has no adverse tax or securities law consequences for the Employers.

(f) Notwithstanding the foregoing, if any Incentive Stock Option is granted to any person at a time when such person owns, within the meaning of Section 424(d) of the Code, more than ten percent (10 %) of the total combined voting power of all classes of stock of the employer corporation (or a parent or subsidiary of such

corporation within the meaning of Section 424 of the Code), the price at which each share of Common Stock covered by such Option may be purchased pursuant to such Option shall not be less than one hundred ten percent (110%) of Fair Market Value (determined as set forth in paragraph (a) of this Section 7) of the shares of Common Stock at the time the Option is granted, and such Option must be exercised within the period specified in the Stock Option Agreement, but in no event later than the tenth anniversary of the date on which the Option was granted.

(g) Stock Option Agreements under this Plan may contain such other terms, provisions and conditions not inconsistent herewith as shall be determined by the Committee, in its discretion, including, without limitation, provisions (i) relating to the vesting and termination of Options; (ii) requiring the giving of satisfactory assurances by the Participant that the shares are purchased for investment and not with a view to resale in connection with a distribution of such shares, and will not be transferred in violation of applicable securities laws; (iii) restricting the transferability of such shares during a specified period; and (iv) requiring the resale of such shares to MHI, at a price as specified in the Stock Option Agreement, if the Participant's employment by the Employers terminates prior to a time specified in the Stock Option Agreement.

(h) All Grants of Qualifying Stock Options hereunder made prior to the date on what shareholders approve that portion of this Plan granting Incentive Stock Options shall be contingent upon subsequent approval of the shareholders of the portion of this Plan, granting Incentive Stock Options.

(i) This Section 7 of the Plan shall terminate on, and no additional Awards shall be granted after, ten years from the first to occur of the date on which the Plan is adopted, or ten years from the date on which the shareholders approved the Plan.

SECTION 8. Stock Appreciation Rights and Phantom Stock. An SAR is a right to receive, without payment (except for applicable withholding taxes) to the Employers, a number of shares of Common Stock, cash or a combination thereof, the amount of which is

determined under paragraph (d) of this Section 8. An SAR may be granted (i) with respect to any Option granted under this Plan, either concurrently with the grant of such Option, or at such later time as determined by the Committee (as to all or any portion of the shares of Common Stock subject to the Option), or (ii) alone, without reference to any related Stock Option. Each SAR granted by the Committee under this Plan shall be subject to the terms and conditions of this Section. SARs awarded under the Plan shall be evidenced by either a Stock Option Agreement or a separate signed Stock Appreciation Right Agreement between the Company and the Participant to whom the SAR is granted. Phantom Stock means an Award with a value equivalent to shares of Common Stock. Each share of Phantom Stock shall represent the right of a Participant to receive an amount equal to the Fair Market Value of a share of Common Stock, determined in the manner established by the Committee at the time of the Award. Each Award of Phantom Stock shall be evidenced by a signed written agreement containing such terms and conditions as the Committee may from time to time determine (the "Phantom Stock Agreement").

(a) Each SAR or share of Phantom Stock granted to any Participant shall relate to the number of shares of Common Stock as shall be determined by the Committee, subject to adjustment as provided in Section 11. In the case of an SAR granted with respect to a Stock Option, the number of shares of Common Stock to which the SAR relates shall be reduced in the same proportion that the holder of such Option exercises with respect to such related Stock Option, and the number of shares subject to an Option shall be reduced in the same proportion that the holder of the SAR exercises with respect to the related Option.

(b) The term of each SAR shall be determined by the Committee. Unless otherwise provided by such Committee, each SAR shall become exercisable at such time or times and to such extent and upon such conditions as the Stock Option to which it relates (if any) is exercisable. In the case of a grant of an SAR to an Officer, either (i) no such SAR may be exercised during the first six (6) months of its term, or (ii) no such SAR may be exercised during the first six (6) months of its term unless the Committee determines to issue Common Stock alone on such exercise and such Common Stock shall not be transferable until the date which is six (6) months following the date of grant of the SAR. Except as provided in the preceding sentence, the Committee may, in its discretion, accelerate the exercisability of any SAR.

(c) An SAR may be exercised, in whole or in part, by giving written notice to the Committee, specifying the number of SARs which the holder wishes to exercise. Upon receipt of such written notice, the Committee shall direct the Company to deliver to the exercising holder within ninety (90) days after receipt of the notice a certificate for the shares of Common Stock or cash or both, as determined by the Committee, to which the holder is entitled. No SAR granted to an Officer may be exercised in whole or in part except during the period described in paragraph (b) hereof,

(d) Subject to the right of the Committee to deliver cash in lieu of shares of Common Stock, the number of shares of Common Stock which shall be issuable upon the exercise of an SAR shall be determined by dividing:

(i) the number of shares of Common Stock as to which the SAR is exercised multiplied by the amount of appreciation in such shares (for this purpose, the "appreciation" shall be the amount by which the Fair Market Value of the shares of Common Stock subject to the SAR on the exercise date exceeds (A) in the case of an SAR related to an Option, the purchase price of the Common Shares under the Option or (B) in the case of an SAR granted alone, without reference to a related Option, an amount which shall be determined by the Committee at the time of the grant, subject to adjustment under Section 11; by

(ii) the Fair Market Value of a share of Common Stock on the exercise date,

In lieu of issuing shares of Common Stock upon the exercise of an SAR, the Committee may elect to pay the holder of an SAR cash equal to the Fair Market Value on the exercise date of any or all of the shares which would otherwise be issuable. No fractional shares of Common Stock shall be issued upon the exercise of an SAR; instead, the holder of the SAR shall be entitled to receive a cash adjustment equal to the same fraction of the Fair Market Value of a share of Common Stock on the exercise date or to purchase the

portion necessary to make a whole share at its Fair Market Value on the date of exercise.

(e) Awards of Phantom Stock shall not entitle the Participant or Beneficiary to any dividend or voting rights or any other rights of a shareholder with respect to such Phantom Stock. However, the Committee may, in its discretion, provide the Participant with dividend equivalents (payable on a current or deferred basis). At any time subsequent to full vesting of Phantom Stock, the Participant may tender his Phantom Stock to the Committee, and MHI shall pay the Participant an amount equal to the then Fair Market Value of the equivalent number of shares of Common Stock; provided, however, that upon such tender, the Participant may receive no further Phantom Stock under this Plan for twelve (12) months following the date of such payment.

SECTION 9. Performance Shares and Units.

(a) The Committee may award to any Participant Performance Shares and/or Performance Units ("Performance Awards"). Each Performance Share shall represent one share of Common Stock. Each Performance Unit shall represent the right of a Participant to receive an amount equal to the value to be determined in the manner established by the Committee at the time of the Award, which value may, without limitation, be equal to the Fair Market Value of one share of Common Stock. Each Performance Award under the Plan shall be evidenced by a signed written agreement containing such terms and conditions as the Committee may from time to time determine (the "Performance Agreement").

(b) At the time of the Performance Award, the Committee shall establish an account (the "Performance Account") for each Participant to whom a Performance Award has been granted. Performance Units and Performance Shares awarded to a Participant shall be credited to the Participant's Performance Account,

(c) The performance period for each Performance Award shall be of such duration as the Committee shall establish at the time of the

award (the "Performance Period") There may be more than one Performance Award in existence for a Participant at any time, and more than one Performance Period applicable to a Participant, and the duration of Performance Periods may differ.

At the time of each Performance Award, the Committee may, in its complete discretion, establish performance target(s) to be achieved within the Performance Period(s). The performance target(s) shall be determined by the Committee using such measures of performance of the Employers over the Performance Period as the Committee shall select. During any Period, the Committee may adjust the performance targets for such Period as it deems equitable in recognition of unusual or non-recurring events affecting the Company, changes in applicable tax laws or accounting principles or such other factors as the Committee may determine. If the Committee determines that the Participant has failed to meet the performance target(s), the Participant will not receive payment of the Performance Award.

Performance Awards will be earned as determined by the Committee in respect of a Performance Period in relation to the degree of attainment of performance target(s),

(d) Performance Awards shall be earned to the extent that their terms and conditions are met. Notwithstanding the foregoing, Performance Awards and any other amounts credited to the Participant's Performance Account shall be payable to the Participant only in accordance with the Performance Agreement. The Committee shall make all payment determinations during the four (4) month period beginning on the first day following the close of the Performance Period. Payment for Performance Awards may be made in a lump sum or in installments, in cash, Common Stock or in a combination thereof as the Committee may determine.

(e) In the event that a Participant's employment by the Employers terminates before the end of a Performance Period with the consent of the Committee, or upon a Participant's death, retirement or disability before the end of a Performance Period, the Committee, taking into consideration the performance of such Participant and the performance of the Employers over such portion of the

Performance Period, may authorize the payment to such Participant (or his legal representative or designated beneficiary) of all or a portion of the amount which would have been paid to him had he continued his employment until the end of the Performance Period. In the event a Participant ceases his employment for any other reason, any unpaid amounts for any outstanding Performance Periods, shall be forfeited.

SECTION 10. Restricted Stock, Restricted Stock Units, and Unrestricted Stock Grants.

(a) At the time of the Award under (b) or (c) below, there shall be established for each Participant a restriction period (the "Restriction Period") which shall lapse (i) upon the completion of a period of time ("Time Goal") as shall be determined by the Committee, or (ii) upon the achievement of stock price goals within certain time periods ("Price/Time Goal") as shall be determined by the Committee provided that, in the case of an award to an Officer, such Time Goal or Price/Time Goal shall last at least until the date which is six (6) months after the date of the Award.

(b) The Committee may award to any Participant any shares of Common Stock, subject to this Section 10 and such other terms and conditions as the Committee may prescribe (such shares being herein called "Restricted Stock"), or subject to no restriction ("Unrestricted Stock Grants"). Each certificate for Restricted Stock shall be registered in the name of the Participant and deposited by him, together with a stock power endorsed in blank, with the Committee. Shares of Restricted Stock awarded under this Plan shall be evidenced by a signed written agreement containing such terms and conditions as the Committee may from time to time determine in its discretion (the "Restricted Stock Agreement"), Shares of Restricted Stock may not be sold, assigned, transferred, pledged or otherwise encumbered, except as hereinafter provided, during the Restriction Period. Except for such restrictions on transfer, the Participant as owner of such shares of Restricted Stock shall have all the rights of a holder of such Common Stock. However, a Participant may hold Restricted Stock in a trust, provided that the Committee may require that the Participant submit an opinion of his legal counsel, satisfactory to the Committee, that

such holding has no adverse tax or securities law consequences for MHI.

With respect to shares of Restricted Stock which are issued subject to a Time Goal, the Committee shall redeliver to the Participant (or the Participant's legal representative or designated beneficiary) the certificates deposited pursuant to paragraph (a) of this Section 10 at the expiration of the Restriction Period. With respect to shares of Restricted Stock which are issued subject to a Price/Time Goal, the Committee shall redeliver to the Participant (or the Participant's legal representative or designated beneficiary) the certificates deposited pursuant to paragraph (b) of this Section 10 at the expiration of the Restriction Period. With respect to shares of Restricted Stock which are issued subject to a Price/Time Goal or Time Goal which fail to meet the goal before the end of the Restriction Period, all such shares shall be forfeited and the Committee shall have the right to complete a blank stock power in order to return such shares to MHI.

(c) The Committee may award to a Participant a right to receive Common Stock or cash equivalent to the Fair Market Value of the Common Stock, in the Committee's discretion, at the end of the Restriction Period ("Restricted Stock Units") subject to achievement of a Time Goal or Price/Time Goal established by the Committee. At the end of the Restriction Period, with respect to Restricted Stock Units which are subject to a Time Goal, the Committee shall deliver notice to the Participant (or the Participant's legal representative or designated beneficiary) as to whether the Participant has achieved the Time Goal. With respect to Restricted Stock Units which are awarded subject to a Price/Time Goal, the Committee shall deliver notice to the Participant (or the Participant's legal representative or designated beneficiary) at the end of the Restriction Period as to whether the Participant has achieved the Price/Time Goal. 1f the Committee determines that a Participant has not achieved the Time Goal or Price/Time Goal, the Participant shall have no further rights with respect to the Restricted Stock or Restricted Stock Units.

(d) In the event a Participant ceases his employment with the Employers with the consent of the Committee or upon the Participant's death, retirement or disability before the end of the Restriction Period and the Participant has received an Award subject to a Time Goal, the restrictions imposed under this Section shall lapse with respect to the number of those shares subject to a Time Goal as shall be determined by the Committee, but in no event less than a number equal to the product of (i) a fraction, the numerator of which is the number of completed months elapsed after the date of Award of the Restricted Stock subject to a Time Goal to the Participant to the date of termination and the denominator of which is the number of months in the Restriction Agreement, multiplied by (ii) the number of shares of Restricted Stock or Restricted Stock Units awarded to the Participant subject to the Time Goal.

In the event a Participant ceases his employment the Employers with the consent of the Committee or upon the Participant's death, retirement or disability before the end of the Restriction Period and the Participant has received an Award subject to a Price/Time Goal, the restrictions imposed under this Section shall lapse upon the achievement of the Price/Time Goal within two (2) years of the Participant's termination of employment with respect to such number of shares or units subject to a Price/Time Goal as shall be determined by the Committee. In no event shall the number of shares or units be less than a number equal to the product of (i) a fraction, the numerator of which is the number of completed months elapsed after the date of award of the Restricted Stock or Restricted Stock Units subject to a Price/Time Goal to the Participant to the date of termination and the denominator of which is the number of months elapsed after the date award of the Restricted Stock or Restricted Stock Units subject to a Price/Time Goal to the Participant to the date of achievement of the Price/Time Goal, multiplied by (ii) the number of shares of Restricted Stock or Restricted Stock Units subject to the Price/Time Goal.

In the event a Participant ceases his employment with the Employers for any other reason, all shares of Restricted Stock theretofore awarded to that Participant which are still subject to

restrictions shall be forfeited and the Committee shall have the right to complete the blank stock power.

SECTION 11. Adjustment of Number of Shares. In the event of a stock dividend or stock split is declared upon the stock, the number of shares of Common Stock then subject to an Award and the number of shares reserved for issuance pursuant to this Plan but not yet covered by an Option shall be adjusted by adding to each of such shares the number of shares which would have been distributable thereon if such shares had been outstanding on the date fixed for determining the stockholders entitled to receive such stock dividend or split. In the event that the outstanding shares of Common Stock shall be changed into or exchanged for a different number or kind of shares of stock or other securities of MHI or of another corporation, whether through reorganization, recapitalization, stock split-up, combination of shares, merger or consolidation, then there shall be substituted for each share of Common Stock reserved for issuance pursuant to the Plan but not yet covered by an Option, the number and kind of other stock or other securities into which each outstanding share of Common Stock shall be so changed or for which each such share shall be exchanged; provided, however, that in the event such change or exchange results from a merger or consolidation, and in the judgment of the Board of Directors of MHI such substitution cannot be effected or would be inappropriate, or if MHI shall sell all or substantially all of its assets, MHI shall use reasonable efforts to effect some other adjustment of each such outstanding Option which the Board of Directors of MHI, in its sole discretion, shall deem equitable. In the event that there shall be any change, other than as described above in this Section, in the number or kind of the outstanding shares of Common Stock or of any stock or other securities into which such shares of Common Stock shall have been changed or for which they shall have been exchanged then, if the Board of Directors of MHI shall determine that such change equitably requires an adjustment in the number or kind of shares theretofore reserved for issuance under the Plan but not yet covered by an Option, and of the shares then subject to an Option or Options, such adjustment shall be made by the Board and shall be effective and binding for all purposes of this Plan and of each Stock Option Agreement. Notwithstanding the foregoing, if any adjustment in the number of shares which may be issued and sold pursuant to options is required by the Code or regulations promulgated thereunder to be approved by the stockholders in order to enable the Company to issue Incentive Stock Options pursuant to this Plan, then no such adjustment shall be made without the approval of the stockholders. In the case of any such substitution or adjustment as provided for in this Section, the option price in each Stock Option Agreement for each share covered thereby prior to such substitution or adjustment will be the total option price for all shares of stock or other securities which shall have been substituted for each share or to which such share shall have been adjusted pursuant to this Section. No adjustment or substitution provided for in this

Section shall require the Company, in any Stock Option Agreement, to sell a fractional share, and the total substitution or adjustment with respect to each Stock Option Agreement shall be limited accordingly. Notwithstanding the foregoing, in the case of Incentive Stock Options, if the effect of the adjustments or substitution is to cause the Option to fail to continue to qualify as an Incentive Stock Option or to cause a modification, extension or renewal of such Option within the meaning of Section 424 of the Code, the Board of Directors of the Company shall use reasonable efforts to effect such other adjustment of each then outstanding Option as the Board, in its sole discretion, deems equitable.

SECTION 12. Change of Control. In the event of a "Change of Control" or "Initial Public Offering" (as both defined herein), all Awards hereunder shall vest immediately. As used herein, a "Change of Control" shall mean and be deemed to have occurred if any person (other than the individuals or entities listed on Attachment A, which may be modified by the Committee from time to time) is or becomes the beneficial owner of 20 percent or more of MHI's Common Stock or a change in the composition of MHI's Board of Directors such that within any period of two consecutive years, persons who at the beginning of such period and whose election, or nomination for election by the shareholders of MHI was approved by a vote of at least two-thirds of the persons who were either directors at the beginning of such period or whose subsequent election or nomination was previously approved in accordance with this clause, cease to constitute at least a majority of the Board of Directors, or if MHI's Board of Directors reaches agreement to merge or consolidate with another entity and MHI is not the surviving corporation, or if all, or substantially all of the assets of MHI are sold, or if MHI shall dissolve or liquidate. An "Initial Public Offering" shall be deemed to occur if MHI offers shares to the public pursuant to a registration filed under Form S-1 or Form S-B2 (or any replacement forms) under the Securities Act of 1933.

SECTION 13. Beneficiary Designation. Each Participant under the Plan may name, from time to time, any beneficiary or beneficiaries (who may be named contingently or successively) to whom any benefit under the Plan is to be paid in case of his death before he receives any or all of such benefit. Each designation will be effective only with the written consent of the Participant's spouse and will revoke all prior designations by that Participant, shall be in the form prescribed by the Committee, and will be effective only when filed by the Participant in writing with the Committee during his lifetime. In the absence of any such designation, benefits remaining unpaid at the Participant's death shall be paid to his estate.

SECTION 14. Tax Withholding.

(a) The Employers shall have the power to withhold, or require a Participant to remit to MHI, an amount sufficient to satisfy any withholding or other tax due from MHI with respect to any amount payable and/or shares issuable under the Plan, and MHI may defer such payment or issuance unless indemnified to its satisfaction.

(b) Subject to the consent of the Committee, due to (i) the exercise of a Non-Incentive Stock Option, (ii) the lapse of restrictions on a Restricted Stock Award, or (iii) the issuance of any other stock award under the Plan, a Participant may make an irrevocable election (an "Election") to (A) have shares of Common Stock otherwise issuable under (i) withheld, or (B) tender back to MHI shares of Common Stock received pursuant to (i), (ii), or (iii), or (C) deliver back to the Company pursuant to (i), (ii), or (iii) previously acquired shares of Common Stock of MHI having a Fair Market Value sufficient to satisfy all or part of the Participant's estimated tax obligations associated with the transaction. Such Election must be made by a Participant prior to the date on which the relevant tax obligation arises (the "Tax Date"). The Committee may disapprove of any Election, may suspend or terminate the right to make Elections, or may provide with respect to any Award under this Plan that the right to make Elections shall not apply to such Awards.

(c) If a Participant is an Officer, then an Election is subject to the following additional restrictions:

(i) No election shall be effective for a Tax Date which occurs within six months of the grant of the award.

(ii) The Election must be made and must be effective during a period beginning on the third business day following the date of release for publication of MHI's quarterly or annual summary statements of earnings and ending on the twelfth business day following such date.

SECTION 15. Indemnification. Each person who is or shall have been a member of the Committee shall be indemnified and held harmless by MHI against and from any loss, cost, liability, or expense that may be imposed upon or reasonably incurred by him in connection with or resulting from any claim, action, suit, or proceeding to which he may be a party or in which he may be involved by reason of any action taken or failure to act under the Plan and against and from any and all amounts paid by him in settlement thereof, with MHI's approval, or paid by him in satisfaction of any judgment in any such action, suit, or proceeding against him, provided he shall give MHI an opportunity, at its own expense, to handle and defend the same before he undertakes to handle and defend it on his own behalf. The foregoing right of indemnification shall not be exclusive of any other rights of indemnification to which such persons may be entitled under MHI's Articles of Incorporation or Bylaws, as a matter of law, or otherwise, or any power that MHI may have to indemnify them or hold them harmless.

SECTION 16. Gender and Number. Except where otherwise indicated by the context, words in the masculine gender when used in the Plan will include the feminine gender, the singular shall include the plural, and the plural shall include the singular.

SECTION 17. Controlling Law. This document shall be construed under the laws of the State of California.

SECTION 18. No Stockholder Rights. No Participant hereunder shall have any rights of a stockholder of MHI by reason of being granted an Award under this Plan, except as specifically provided with respect to Restricted Stock.

SECTION 19. Amendments. This Plan may be amended from time to time by written resolution of the Board of Directors of MHI; provided, however, that no amendment which shall (i) change the total number of shares which may be issued and sold pursuant to Options granted under this Plan, (ii) change the designation of the class of employees eligible to receive Incentive Stock Options or the class of individuals eligible to receive Non-Incentive Stock Options, (iii) decrease the minimum Option price set forth in paragraph (a) of Section 7 of this Plan, (iv) extend the period during which an Option may be granted or exercised beyond the maximum period specified in this Plan, or (v) withdraw the authority to administer this Plan from the Committee, shall be effective without the approval of the stockholders. Notwithstanding the foregoing, the Board may amend the Plan to incorporate or conform to requirements imposed by and amendments made to the Code or regulations promulgated thereunder which the Board deems to be necessary or desirable to preserve (a) incentive stock option status for outstanding Incentive Stock Options and to preserve the ability to issue Incentive Stock Options pursuant to this Plan,

(b) the deductibility by MHI of amounts taxed to Plan Participants as ordinary compensation income, and (c) the status of any Award as exempt from registration requirements under any securities law for which the Award was intended to be exempt.

SECTION 20. Termination or Suspension. The Board of Directors of MHI may terminate the Plan or any portion thereof at any time by written resolution. No suspension or termination shall impair the rights of Participants under outstanding Awards without the consent of the Participants affected thereby.

Attachment A

Joseph Marion Molina, M.D.

John Conrad Molina

Mary R. Molina

Martha Bernadett, M.D.

Josephine Battiste

Janet Walt

Molina Marital Trust

Mary R. Molina Living Trust

Molina Family Ltd. Partnership

Molina Siblings Trust

SECRETARY'S CERTIFICATE

I, Mark L. Andrews, in my capacity as Secretary of Molina Healthcare, Inc., hereby confirm that the attached Omnibus Stock and Incentive Plan has been amended pursuant to shareholder action taken on December 18, 2000.

IN WITNESS WHEREOF, I have hereunto subscribed my name this 2nd day of October, 2001.

/s/

Mark L. Andrews
Corporate Secretary

EXHIBIT 10.13

MOLINA HEALTHCARE, INC.

2002 EQUITY INCENTIVE PLAN

SECTION 1. GENERAL PURPOSE OF THE PLAN & DEFINITIONS

The name of the plan is the Molina Healthcare, Inc. 2002 Equity Incentive Plan (the "Plan"). The purpose of the Plan is to encourage and enable the officers, directors, employees and Consultants of Molina Healthcare, Inc., a California corporation (the "Company"), and its Subsidiaries (each as defined below), upon whose judgment, initiative and efforts the Company largely depends for the successful conduct of its business, to acquire a proprietary interest in the Company. It is anticipated that providing such persons with a direct stake in the Company's welfare will assure a closer identification of their interests with those of the Company, thereby stimulating their efforts on the Company's behalf and strengthening their desire to remain with and further the interests of the Company.

The following terms shall be defined as set forth below:

"Acquired Company" has the meaning specified in Section 10(c).

"Act" means the Securities Act of 1933, as amended.

"Assumption" has the meaning specified in Section 10(b).

"Award" or "Awards" shall include Incentive Stock Options, Non-Qualified Stock Options, Restricted Stock Awards, Stock Bonus Awards or any combination of the foregoing.

"Board" means the Board of Directors of the Company or its successor entity.

"Code" means the Internal Revenue Code of 1986, as amended, and related rules, regulations and interpretations.

"Committee" has the meaning specified in Section 2(a).

"Company" has the meaning specified in the first para graph of Section 1.

"Consultant" means a person engaged to provide consulting or advisory services (other than as an employee or director) to the Company or any Subsidiary; provided that, the identity of such person, the nature of such services or the entity to which such services are provided would not preclude the Company from offering or selling securities to such person pursuant to the Plan in reliance on a Form S-8 Registration Statement under the Act.

"Covered Employee" means an employee described in Section 162(m)(3) of the Code.

"Disability" has the meaning specified in Section 22(e)(3) of the Code.

"Effective Date" has the meaning specified in Section 14.

"Exchange Act" means the Securities Exchange Act of 1934, as amended.

"Fair Market Value" of a share of Stock for a given date means (i) the last reported closing price for a share of Stock on the NYSE; or (ii) in the absence of reported sales on the NYSE on a given date, the closing price of the NYSE on the last date on which a sale occurred prior to such date; or (iii) if the stock is no longer publicly traded on the NYSE, the Committee in good faith shall determine Fair Market Value; provided that, if the date for which the Fair Market Value is determined is the first day when trading prices for the Stock are reported on the NYSE, the Fair Market Value shall be the public offering price set forth on the cover page for the final prospectus relating to the Company's Initial Public Offering.

"Incentive Stock Option" means any Stock Option designated and qualified as an "incentive stock option" as defined in Section 422(b) of the Code.

"Initial Public Offering" means the consummation of the first fully underwritten, firm commitment, public offering pursuant to an effective registration statement under the Act, other than on Forms S-4 or S-8 or their then equivalents, covering the offer and sale by the Company of its equity securities or such other event as a result of or following which the Stock shall be publicly held.

"NYSE" means the New York Stock Exchange.

"Non-Qualified Stock Option" means any Stock Option that is not designated as an Incentive Stock Option or which does not qualify as an Incentive Stock Option.

"Option" or "Stock Option" means any right to purchase shares of Stock granted pursuant to Section 5.

"Option Agreement" means a written agreement between the Company and a grantee setting forth the terms, conditions and restrictions of the Option granted to the grantee and any shares of Stock acquired upon the exercise thereof. An Option Agreement may consist of a "Notice of Grant of Stock Option" and a form of "Stock Option Agreement" incorporated therein by reference or such other form or forms as the Committee may approve from time to time.

"Option Shares" means the shares of Stock which are issuable upon exercise of a Stock Option.

"Outside Director" means an individual who meets the requirements to qualify as an "outside director" as defined under Treas. Reg. Sect. 1.162-27(e)(3) (or its successor).

"Plan" has the meaning specified in the first paragraph of Section 1.

"Prior Plan" has the meaning specified in Section 3(b).

"Reincorporation Merger" means the merger contemplated by that certain Agreement of Merger by and between the Company and Molina Healthcare, Inc., a Delaware corporation, as amended.

"Restricted Stock" has the meaning specified in Section 6(a).

"Restricted Stock Agreement" means a written agreement between the Company and a grantee setting forth the terms, conditions and restrictions of a Restricted Stock Award granted to the grantee and any shares of Restricted Stock issued to the grantee pursuant thereto.

"Restricted Stock Award" means any Award of Restricted Stock hereunder.

"Service Relationship" means the grantee's employment or service with the Company or any Subsidiary, whether in the capacity of an employee, director or Consultant. Unless otherwise determined by the Committee, a grantee's Service Relationship shall not be deemed to have terminated merely because of a change in the capacity in which the grantee renders service to the Company or its Subsidiary, or a transfer between locations of the Company or any Subsidiary or a transfer between the Company and any Subsidiary; provided that, there is no interruption or other termination of the Service Relationship. Subject to the foregoing and Section 9 below, the Company, in its sole discretion, shall determine whether the grantee's Service Relationship has terminated and the effective date of such termination.

"Stock" means the common stock, par value $0.001 per share, of the Company, subject to adjustment pursuant to Section 3.

"Stock Bonus Award" has the meaning specified in Section 7.

"Stock Option" means an Award on an option to purchase shares of Stock under Section 5.

"Subsidiary" means any corporation (other than the Company) in any unbroken chain of corporations beginning with the Company if each of the corporations (other than the last corporation in the unbroken chain) owns stock possessing fifty percent (50%) or more of the total combined voting power of all classes of stock in one of the other corporations in the chain.

"Transaction" means any of the following:

(a) Approval by the Board and by the shareholders of the Company (or, if no shareholder approval is required, by the Board alone) of the dissolution or liquidation of the Company, other than in the context of a transaction that does not constitute a Transaction under paragraph (b) below,

(b) Consummation of a merger, consolidation, or other reorganization, with or into, or the sale of all or substantially all of the Company's business and/or assets as an entirety to, one or more entities that are not subsidiaries or affiliates of the Company (a "Business Combination"), unless (1) as a result of the Business Combination, more than fifty percent of the outstanding voting power generally in the election of directors of the surviving or resulting entity

or a parent thereof (the "Successor Entity") immediately after the reorganization is, or will be, owned, directly or indirectly, by holder of the Company's voting securities immediately before the Business Combination; and (2) no "person" (as such term is used in Sections 13(d) and 14(d) of the Exchange Act), excluding the Successor Entity or an Excluded Person, beneficially owns, directly or indirectly, more than fifty percent of the outstanding shares or the combined voting power of the outstanding voting securities of the Successor Entity, after giving effect to the Business Combination, except to the extent that such ownership existed before the Business Combination.

(c) Any "person" (as such term is used in Sections 13(d) and 14(d) of the Exchange Act) other than an Excluded Person becomes the "beneficial owner" (as defined in Rule 13d-3 under the Exchange Act), directly or indirectly, of securities of the Company representing more than fifty percent of the combined voting power of the Company's then outstanding securities entitled to then vote generally in the election of directors of the Company, other than as a result of (1) an acquisition directly from the Company, (2) an acquisition by the Company or (3) an acquisition by an entity pursuant to a transaction that is expressly excluded under paragraph (b) above.

For purposes of defining whether an event qualifies as a "Transaction," "Excluded Person" shall mean (1) any person described in and satisfying the conditions of Rule 13d-1(b)(1) under the Exchange Act, (2) the Company, (3) an employee benefit plan (or related trust) sponsored or maintained by the Company or the Successor Entity or (4) any person who is the "beneficial owner" (as defined in Rule 13d-3 under the Exchange Act) of more than twenty-five percent of the Stock on January 1, 2002 (or an affiliate, successor, heir, descendant, or related party of or to such person).

"10% Owner Optionee" means an individual who owns or is deemed to own (by reason of the attribution rules of Section 424(d) of the Code) more than ten percent (10%) of the combined voting power of all classes of stock of the Company, or of its Parent or any Subsidiary.

SECTION 2. ADMINISTRATION OF PLAN

(a) Administration of Plan. The Plan shall be administered by the Board of Directors of the Company (the "Board"), or at the discretion of the Board, a committee of the Board consisting of not less than two directors (the "Committee"); provided that, if each member of the Committee is not a "Non-Employee Director" within the meaning of Rule 16b-3(a)(3) of the Exchange Act, then any Awards granted to individuals subject to the reporting requirements of Section 16 of the Exchange Act shall be approved by the Board. Notwithstanding the foregoing, after the end of the reliance period (as defined in Treasury Regulation 1.162-27(f)) following the Company's Initial Public Offering, Awards granted to Covered Employees which might reasonably be anticipated to result in the payment of employee remuneration that would otherwise exceed the limit on employee remuneration deductible for income tax purposes pursuant to Section 162(m) of the Code shall be approved by a Committee composed solely of two or more Outside Directors. All references herein to the Committee shall be deemed to refer to the entity then responsible for administration of the Plan at the relevant time (i.e., either the Board or a committee of the Board, as applicable).

(b) Powers of Committee. The Committee shall have the power and authority to grant Awards consistent with the terms of the Plan, including the power and authority:

(i) to select the persons to whom Awards may from time to time be granted;

(ii) to determine the time or times of grant and the type of Award to be granted which may include Incentive Stock Options, Non-Qualified Stock Options, Restricted Stock Awards, Stock Bonus Awards or any combination of the foregoing, granted to any one or more grantees;

(iii) to determine the number of shares of Stock to be covered by any Award;

(iv) to approve the form of written instruments evidencing the Awards;

(v) to determine and modify from time to time the terms and conditions of any Award, including restrictions, not inconsistent with the terms of the Plan, which terms and conditions may differ among individual Awards and grantees;

(vi) to accelerate at any time the exercisability or vesting of all or any portion of any Award and/or to include provisions in Awards providing for such acceleration;

(vii) to impose any limitations on Awards granted under the Plan, including limitations on transfers, repurchase provisions and the like and to exercise repurchase rights or obligations;

(viii) to extend at any time the period in which Stock Options may be exercised; and

(ix) at any time to adopt, alter and repeal such rules, guidelines and practices for administration of the Plan and for its own acts and proceedings as it shall deem necessary and advisable; to interpret the terms and provisions of the Plan and any Award (including related written instruments); to make all determinations it deems necessary and advisable for the administration of the Plan; to decide all disputes arising in connection with the Plan; and to otherwise supervise the administration of the Plan.

All decisions and interpretations of the Committee relating to the Plan and any Awards granted hereunder shall be binding on all persons, including the Company, the Company's stockholders, grantees and beneficiaries.

(c) Delegation of Authority to Grant Awards. The Committee, in its discretion and in accordance with applicable state law, may delegate to the Chief Executive Officer of the Company all or part of the Committee's authority and duties with respect to the granting of Awards at Fair Market Value to individuals who are not subject to the reporting requirements of Section 16 of the Exchange Act or Covered Employees. The Committee may revoke or amend the terms of a delegation at any time but such action shall not invalidate any prior actions of the Committee's delegate or delegates that were consistent with the terms of the Plan.

SECTION 3. STOCK ISSUABLE UNDER THE PLAN

(a) Initial Stock Reserve. The maximum aggregate number of shares of Stock reserved and available for issuance under the Plan shall be 40,000 shares of Stock, subject to adjustment as provided in Section 10(a). For purposes of this limitation, the shares of Stock underlying any Awards which are forfeited, canceled, reacquired by the Company, satisfied without the issuance of Stock or otherwise terminated (other than by exercise) without the issuance of Stock shall be added back to the shares of Stock available for grant and issuance in connection with future Awards under this Plan. The sum of Restricted Stock Awards and Stock Bonus Awards issued under this Plan shall not exceed 15,000 shares, subject to adjustment under Section 10(a).

(b) Coordination with Prior Plan

Any authorized shares not issued or subject to outstanding grants under the Omnibus Stock and Incentive Plan for Molina Healthcare, Inc. (the "Prior Plan") on the Effective Date and any shares that are issuable upon exercise of options granted under the Prior Plan that expire or become unexercisable for any reason without having been exercised in full, will no longer be available for grant and issuance under the Prior Plan but will be available for grant and issuance under this Plan. In addition, any shares issued under the Prior Plan that are repurchased or forfeited will be available for grant and issuance under this Plan.

(c) Annual Increase to Stock Reserve

On the first business day of each fiscal year of the Company on or after the Effective Date but prior to termination of the Plan, the aggregate number of shares of Stock reserved and available for grant and issuance under this Plan will be increased automatically by a number of shares of Stock equal to the lesser of (i) 10,000 shares of Stock, subject to adjustment under Section 10(a) below, and (ii) the number of shares of Stock equal to two percent (2%) of the issued and outstanding Common Shares (calculated on a fully-diluted (including all Stock issuable under the Plan) and as-converted basis) determined as of the date of the applicable increase, unless the Board determines prior to the commencement of any fiscal year that such increase shall not occur for such fiscal year.

(d) Shares Available for Issuance. The shares of Stock available for issuance under the Plan may be authorized but unissued shares of Stock or shares of Stock reacquired by the Company and held in its treasury. At all times, the Company shall reserve and keep available a sufficient number of shares of stock as shall be required to satisfy the requirements of all outstanding stock options granted under the Plan and all other outstanding but unvested Awards.

SECTION 4. ELIGIBILITY

Awards may be granted to employees, directors and Consultants of the Company or any Subsidiary (including prospective employees, directors and Consultants to whom Awards are granted in connection with written offers of employment or other service with the Company or any subsidiary) as are selected from time to time by the Committee in its sole discretion on and after the Company's Initial Public Offering. The Board shall consider such factors as it deems

pertinent in selecting who shall receive Awards and in determining the type and amount of their benefits under this Plan. A person may be granted more than one Award under this Plan. The maximum number of Common Shares subject to a benefit that may be granted in the aggregate under the Plan during any calendar year to any person shall be limited to 15,000 shares (subject to adjustment pursuant to Section 10(a) below). To the extent required by Section 162(m) of the Code, Awards subject to the foregoing limit that are cancelled or repriced during any year continue to be counted against this limit.

SECTION 5. STOCK OPTIONS

The Company may grant Stock Options under the Plan to any eligible person pursuant to an Option Agreement that shall be in such form as the Committee may from time to time approve. Option Agreements need not be identical.

Stock Options granted under the Plan may be either Incentive Stock Options or Non-Qualified Stock Options. Incentive Stock Options may be granted only to employees of the Company or any Subsidiary; provided that, an Incentive Stock Option may be granted to a prospective employee upon the condition that such person becomes an employee and such grant shall be deemed granted effective on the date that such person commences service with the Company or any Subsidiary, with an exercise price determined as of such date in accordance with Section 5(a)(i) below. Non-Qualified Stock Options may be granted to officers, directors, employees and Consultants of the Company or any Subsidiary. To the extent that any Option does not qualify as an Incentive Stock Option, it shall be deemed a Non-Qualified Stock Option.

No Incentive Stock Option shall be granted under the Plan on or after the tenth anniversary of the Board's adoption of the Plan.

(a) Terms of Stock Options. Stock Options granted under the Plan shall be subject to the following terms and conditions and shall contain such additional terms and conditions, not inconsistent with the terms of the Plan, as the Committee shall deem desirable:

(i) Exercise Price. The exercise price per share for the Stock covered by a Stock Option shall be determined by the Committee at the time of grant but shall not be less than one hundred percent (100%) of the Fair Market Value on the grant date in the case of an Incentive Stock Option. If an Incentive Stock Option is granted to a 10% Owner Optionee, the exercise price per share for the Stock covered by such Incentive Stock Option shall not be less than one hundred ten percent (110%) of the Fair Market Value on the grant date. Notwithstanding the foregoing, an Incentive Stock Option may be granted with an exercise price lower than the minimum exercise price per share set forth above if the Incentive Stock Option is granted pursuant to a substitution for an option of an Acquired Company in a manner qualifying under Section 424(a) of the Code.

(ii) Option Term. The term of each Stock Option shall be fixed by the Committee, but no Stock Option shall be exercisable more than ten (10) years after the date the Stock Option is granted. If an Incentive Stock Option is granted to a 10% Owner Optionee, such Incentive Stock Option shall not be exercisable more than five (5) years after the grant date.

(iii) Exercisability; Rights of a Stockholder. Stock Options shall become exercisable at such time or times, whether or not in installments, as shall be determined by the Committee and set forth in the Option Agreement evidencing such Option. A grantee shall have no rights of a stockholder of the Company with respect to any shares covered by the Option until the date of the issuance of the shares of Stock for which the Option has been exercised (as evidenced by an appropriate entry on the books of the Company or of a duly authorized transfer agent of the Company). No adjustment shall be made for dividends, distributions or other rights for which the record date is prior to the date such shares are issued, except as provided in Section 10(a) hereof.

(iv) Method of Exercise. Stock Options may be exercised, in whole or in part, by giving written notice of exercise to the Company, specifying the number of shares of Stock to be purchased. Payment of the aggregate exercise price may be made by one or more of the following methods to the extent provided in the Option Agreement:

(A) in cash, by certified or bank check, or other instrument acceptable to the Committee in U.S. funds payable to the order of the Company in an amount equal to the aggregate exercise price of such Option Shares;

(B) if permitted by the Committee in its sole and absolute discretion, (x) through the delivery (or attestation to ownership) of shares of Stock with an aggregate Fair Market Value (as of the date such shares are delivered or attested to) equal to the aggregate Exercise Price and that have been purchased by the grantee on the open market or that have been held by the grantee for at least six (6) months and are not subject to restrictions under any plan of the Company, or (y) by the grantee delivering to the Company a properly executed exercise notice together with irrevocable instructions to a broker to promptly deliver to the Company cash or a check payable and acceptable to the Company in an amount equal to the aggregate exercise price; provided that, in the event the grantee chooses such payment procedure, the grantee and the broker shall comply with such procedures and enter into such agreements of indemnity and other agreements as the Committee shall prescribe as a condition of such payment procedure; or

(C) a combination of the payment methods set forth in clauses (A) and (B) above.

Payment instruments will be received subject to collection. No certificates for Option Shares so purchased will be issued to the grantee until the Company has completed all steps required by law to be taken in connection with the issuance and sale of such shares, including, without limitation, obtaining from grantee payment or provision for all withholding taxes due as a result of the exercise of the Stock Option. The issuance of the Option Shares to be purchased pursuant to the exercise of a Stock Option will be contingent upon receipt from the grantee (or a purchaser acting in his or her stead in accordance with the provisions of the Stock Option) by the Company of the full exercise price for such Option Shares and the fulfillment of any other requirements contained in the Option Agreement or applicable provisions of law. If the grantee chooses to pay the exercise price by delivery of previously owned shares of Stock by the attestation method set forth in clause (B)(x) above, the shares of Stock issued to the grantee upon the exercise of the Stock Option shall be net of the number of the shares of Stock delivered.

(b) Annual Limit on Incentive Stock Options. To the extent that the aggregate Fair Market Value (determined as of the time the Option is granted) of the shares of Stock with respect to which Incentive Stock Options are exercisable for the first time by a grantee during any calendar year (under all option plans of the Company and its Subsidiaries) exceeds $100,000, such Incentive Stock Options shall constitute Non-Qualified Stock Options. For purposes of this Section 5(b), Incentive Stock Options shall be taken into account in the order in which they were granted. If pursuant to the above, an Incentive Stock Option is treated as an Incentive Stock Option in part and a Non-Qualified Stock Option in part, the grantee may designate which portion of the Stock Option the grantee is exercising. In the absence of such designation, the grantee shall be deemed to have exercised the Incentive Stock Option portion of the Stock Option first.

(c) Non-transferability of Options. No Stock Option shall be transferable by the grantee other than by will or by the laws of descent and distribution and all Stock Options shall be exercisable, during the grantee's lifetime, only by the grantee or by the grantee's legal representative or guardian in the event of the grantee's incapacity. Notwithstanding the foregoing, the Committee, in its sole discretion, may provide in the Option Agreement regarding a given Non-Qualified Stock Option that the grantee may transfer, without consideration for the transfer, such Stock Option to members of his or her immediate family, to trusts for the benefit of such family members, to partnerships in which such family members are the only partners or to limited liability companies in which such family members are the only members; provided that, each transferee agrees in writing with the Company to be bound by all of the terms and conditions of the Plan and the applicable Option Agreement.

SECTION 6. RESTRICTED STOCK AWARDS

(a) Nature of Restricted Stock Awards. The Company may grant or sell, at par value or such greater purchase price as determined by the Committee, in its sole discretion, shares of Stock subject to such restrictions and conditions as the Committee may determine at the time of grant ("Restricted Stock"), which purchase price shall be payable in cash or, if permitted by the Committee at the time of grant of such Award, by promissory note (which may be recourse or partially recourse to the grantee), in a form approved by the Committee; provided that, at least so much of the purchase price as represents the par value of the Stock shall be paid other than with a promissory note if required by state law. Conditions may be based on the continuation of a Service Relationship, achievement of pre-established performance goals and objectives or such other terms as may be determined by the Committee in its sole discretion. The grant of a Restricted Stock Award is contingent on the grantee executing a Restricted Stock Agreement. The terms and conditions of each such Restricted Stock Agreement shall be determined by the Committee and such terms and conditions may differ among individual Awards and grantees.

(b) Rights as a Stockholder. Upon execution of the Restricted Stock Agreement and payment of any applicable purchase price, a grantee shall have the rights of a stockholder of the Company with respect to the voting of the Restricted Stock, subject to such conditions contained in the Restricted Stock Agreement. Unless the Committee shall otherwise determine, certificates evidencing the Restricted Stock shall remain in the possession of the Company until such

Restricted Stock is vested as provided in Section 6(d) below and the grantee shall be required, as a condition of the grant, to deliver to the Company a stock power endorsed in blank.

(c) Restrictions. Restricted Stock may not be sold, assigned, transferred, pledged or otherwise encumbered or disposed of except as specifically provided herein or in the Restricted Stock Agreement. Shares of Stock issued pursuant to a Restricted Stock Award may be subject additional conditions and restrictions as determined by the Committee and set forth in the applicable Restricted Stock Agreement, including but not limited to, compliance with post-employment obligations to the Company.

(d) Vesting of Restricted Stock. The Committee at the time of grant shall specify the date or dates and/or performance goals, objectives and other conditions on which Restricted Stock shall become vested, subject to such further rights of the Company or its assigns as may be specified in the Restricted Stock Agreement.

(e) Waiver, Deferral and Reinvestment of Dividends. The Restricted Stock Agreement may require or permit the immediate payment, waiver, deferral or investment of dividends paid on the Restricted Stock.

SECTION 7. STOCK BONUS AWARDS

The Committee may, in its sole discretion, grant or sell, at par value or such greater purchase price determined by the Committee, in exchange for any valid consideration, including past services rendered, a Stock Bonus Award to any grantee, pursuant to which such grantee may receive shares of Stock under the Plan free of any vesting restrictions ("Stock Bonus Award"). Notwithstanding the foregoing, Stock received pursuant to a Stock Bonus Award may be subject to other conditions and restrictions as determined by the Committee, including but not limited to compliance with post-employment obligations to the Company, at the time of grant and the Committee may place legends referencing any such restrictions on the certificate representing such Stock.

SECTION 8. TAX WITHHOLDING

(a) Payment by Grantee. Each grantee shall pay to the Company, or make arrangements satisfactory to the Committee regarding payment of, any federal, state or local taxes of any kind required by law to be withheld with respect to such income no later than the date as of which the value of an Award or any Stock or other amounts received thereunder first becomes includable in the gross income of the grantee for tax purposes. The Company shall, to the extent permitted by law, have the right to deduct any such taxes from any payment of any kind otherwise due to the grantee.

(b) Payment in Stock. Subject to approval by the Committee, an individual may elect to have the minimum required tax withholding obligation (as determined under applicable federal, state or local law) satisfied with respect to an Award, in whole or in part, by: (i) authorizing the Company to withhold from shares of Stock to be issued pursuant to any Award a number of shares with an aggregate Fair Market Value (as of the date the withholding is effected) that would satisfy such obligation, or (ii) transferring to the Company shares of Stock

owned by the grantee with an aggregate Fair Market Value (as of the date the withholding is effected) that would satisfy such obligation.

SECTION 9. LEAVE OF ABSENCE

(a) Exercisability. An approved leave of absence for military service, sickness or any other purpose approved by the Company shall not be deemed a termination of a grantee's Service Relationship for purposes of determining when a grantee's outstanding Stock Options will expire pursuant to the Plan and the applicable Option Agreement; provided that, if any such leave exceeds ninety (90) days, on the ninety-first (91st) day of such leave the grantee's Service Relationship shall be deemed to have terminated unless the grantee's right to return to service is guaranteed by either statute or contract.

(b) Vesting. An approved leave of absence for maternity or, in the Company's sole discretion, a medical reason, shall be treated as service for purposes of determining vesting under a grantee's outstanding Award agreements; provided that, if any such leave exceeds twelve (12) weeks then, beginning on the first (1st) day of the thirteenth (13th) week, such leave shall not be treated as service for purposes of vesting (i.e., the vesting schedule shall be tolled for the period of the leave of absence beyond twelve (12) weeks). Notwithstanding anything stated in this Section 9(b), unless otherwise designated by the Company or required by law, any other leave of absence shall not be treated as service for purposes of vesting.

SECTION 10. CORPORATE TRANSACTIONS

(a) Changes in Stock. If, as a result of (i) any reorganization, recapitalization, reclassification, stock dividend, stock split, reverse stock split or other similar change in the Company's capital stock without consideration, (ii) the outstanding shares of Stock being increased or decreased or being exchanged for a different number or kind of shares or other securities of the Company, (iii) additional shares or new or different shares or other securities of the Company or other non-cash assets being distributed with respect to such shares of Stock or other securities, or (iv) a merger, consolidation or sale of all or substantially all of the assets of the Company, outstanding shares of Stock are converted into or exchanged for a different number or kind of shares or other securities of the Company or any successor entity (or a parent or subsidiary thereof) (including the Reincorporation Merger), the Committee shall make an appropriate or proportionate adjustment in: (v) the maximum number of shares reserved for issuance under the Plan, including annual increases under Section 3(c) and limits on Restricted Stock Awards and Stock Bonus Awards under Section 3(a), (x) the number and kind of shares or other securities subject to any then outstanding Awards under the Plan, (y) maximum number of shares of Stock that may be issued to a person under Section 4, and (z) the exercise price for each share subject to any then outstanding Stock Option under the Plan, without changing the aggregate exercise price (i.e., the exercise price multiplied by the number of shares subject to the Stock Option); provided that such exercise price may not be less than the par value of the Stock after any such adjustment The adjustment by the Committee shall be final, binding and conclusive. No fractional shares of Stock shall be issued under the Plan resulting from any such adjustment, but the Committee in its discretion may either make a cash payment in lieu of fractional shares or round any resulting fractional share down to the nearest whole number.

Notwithstanding the foregoing, the required adjustment under this Section 10(a) in connection with the effectiveness of the Reincorporation Merger, shall be consistent with the adjustment made to all then outstanding shares of the Common Stock of the Company.

(b) Mergers and Other Transactions. Upon the effectiveness of a Transaction, unless provision is made in connection with the Transaction for the assumption of a grantee's outstanding Award granted hereunder, or the substitution of such Award with a new Award of the successor entity or parent thereof, with appropriate adjustment as to the number and kind of shares and, if appropriate, the per share exercise and/or repurchase prices, as provided in Section 10(a) above (the "Assumption"), such Award shall terminate and, if such Award is a Stock Option, the grantee shall be permitted to exercise such Stock Option to the extent that it is then vested and exercisable (after giving effect to the acceleration of vesting provided for in connection with the Transaction, if any) for a period of at least ten (10) days prior to the date of such termination; provided that, the exercise of the portion of such Stock Option that becomes vested and exercisable in connection with the Transaction, if any, shall be subject to and conditioned upon the effectiveness of the Transaction. In addition, if no Awards are assumed or substituted for in an Assumption, this Plan shall terminate upon the effectiveness of such Transaction. In the Committee's sole and absolute discretion, Award agreements may contain additional terms and conditions, not inconsistent with the foregoing, that will apply in the event a Transaction occurs.

(c) Awards. The Committee may grant Awards under the Plan in substitution for stock and stock based awards held by employees, directors or consultants of another company (an "Acquired Company") in connection with a merger or consolidation of such Acquired Company with the Company (or any Subsidiary) or the acquisition by the Company (or any Subsidiary) of property or stock of the Acquired Company. The Committee may direct that the substitute Awards be granted on such terms and conditions as the Committee considers appropriate in the circumstances. Any substitute Awards granted under the Plan shall not count against the share limitation set forth in Section 3(a) above.

(d) Dissolution or Liquidation. Upon the effectiveness of a dissolution or liquidation of the Company, any outstanding Stock Options issued under the Plan shall be terminated if not exercised prior to such event.

SECTION 11. AMENDMENTS AND TERMINATION

The Board may, at any time, amend or discontinue the Plan, but no such action shall adversely affect rights under any outstanding Award without the holder's consent unless required: (i) to ensure that a Stock Option is treated as an Incentive Stock Option, or (ii) to comply with applicable law. Except as herein provided, no such action of the Board, unless taken with the approval of the stockholders of the Company, may: (a) increase the maximum number of shares of Stock for which Awards granted under this Plan may be issued including annual increases under Section 3(c) and limits on Restricted Stock Awards and Stock Bonus Awards under Section 3(a) (except by operation of Section 10(a)); (b) the maximum number of shares of Stock that may be issued to a person under Section 4; (c) alter the class of employees eligible to receive Incentive Stock Options under the Plan; or (d) amend the Plan in any other

manner which the Board, in its discretion, determines would require the approval of the stockholders under any applicable law, rule or regulation to become effective even though such stockholder approval is not expressly required by this Plan. No termination or amendment of the Plan shall affect any outstanding Award unless expressly provided thereby or hereunder or as determined by the Board. Nothing in this Section 11 shall limit the Board's or Committee's authority to take any action permitted pursuant to Section 10(b). The Plan shall continue in effect until the earlier of: (i) the tenth anniversary of the Board's adoption of the Plan, or (ii) the date on which all of the shares of Stock available for issuance under the Plan have been issued and all restrictions on such shares under the terms of the Plan and the Option Agreements and Restricted Stock Agreements covering such shares have lapsed.

SECTION 12. STATUS OF PLAN

With respect to the portion of any Award that has not been exercised and any payments in cash, Stock or other consideration payable under any Award which is not received by a grantee, a grantee shall have no rights greater than those of a general creditor of the Company unless the Committee shall otherwise expressly determine in connection with any such Award.

SECTION 13. GENERAL PROVISIONS

(a) No Distribution; Compliance with Legal Requirements. The grant of Awards and the issuance of shares of Stock pursuant thereto shall be subject to compliance with all applicable requirements of federal, state and local law with respect to such securities. Options may not be exercised if the issuance of shares of Stock upon exercise would constitute a violation of any applicable federal or state securities laws or other laws or regulations or the requirements of any stock exchange or market system upon which the Stock may then be listed. In addition, no Option may be exercised unless: (a) a registration statement under the Act shall at the time of exercise of the Option be in effect with respect to the shares of Stock issuable upon exercise of the Option, or (b) the shares of Stock issuable upon exercise of the Option may be issued in accordance with the terms of an applicable exemption from the registration requirements of the Act. The inability of the Company to obtain from any regulatory body having jurisdiction the authority, if any, deemed by Company's legal counsel to be necessary for the lawful issuance and sale of any shares hereunder shall relieve the Company of any liability in respect of the failure to issue or sell such shares as to which such requisite authority shall not have been obtained. As a condition to the exercise of any Option, the Company may require the grantee to satisfy any qualifications that may be necessary or appropriate, to evidence compliance with any applicable law or regulation and to make any representation or warranty with respect thereto as may be requested by the Company.

(b) Delivery of Stock Certificates. Stock certificates issued under this Plan shall be deemed delivered for all purposes when delivered in person or when the Company or a stock transfer agent of the Company shall have mailed such certificates by U.S. mail, addressed to the grantee, at the grantee's last known address on file with the Company. All Stock certificates delivered under the Plan are subject to any stop-transfer orders and other restrictions as the Committee deems necessary or advisable to comply with federal, state, local or foreign laws, rules and regulations and the rules of the NYSE or any national securities exchange or

automated quotation system on which the Stock is listed, quoted or traded. The Committee may place legends on any Stock certificate to reference restrictions applicable to the Stock. In addition to the terms and conditions provided herein, the Committee may require that a grantee make such reasonable covenants, agreements and representations as the Committee, in its discretion, deems advisable in order to comply with any such laws, rules and regulations.

(c) Other Compensation Arrangements; No Employment Rights. Nothing contained in this Plan shall prevent the Committee from adopting other or additional compensation arrangements and such arrangements as may be either generally applicable or applicable only in specific cases. The adoption of this Plan and the grant of Awards do not confer upon any grantee any right to continued employment or service with the Company or any Subsidiary or interfere in any way with the right of the Company or any Subsidiary to terminate the grantee's employment or service at any time.

(d) Compensation, Severance and Other Benefits. Awards granted under the Plan shall not be considered part of any grantee's ordinary salary for purposes of pension benefits, severance, redundancy, resignation or any other purpose. If a grantee's Service Relationship is terminated for any reason, the grantee shall not be entitled to damages for breach of contract, dismissal or compensation for loss of office and shall not be entitled to any other sum, shares or other benefits to compensate for the loss or diminution in value of any actual or prospective rights, benefits or expectations under or in relation to the Plan.

(e) Trading Policy Restrictions. Stock received pursuant to this Plan or upon exercise of an Award under the Plan shall be subject to any insider trading policy-related restrictions, terms and conditions as may be established by the Committee or in accordance with policies set by the Committee from time to time.

(f) Conflict with Agreement, Notice. In the event of a conflict between the terms and provisions of this Plan and the terms and provisions of any agreement to issue an Award, the terms and provisions of this Plan shall govern.

SECTION 14. EFFECTIVE DATE

This Plan shall be effective on the date (the "Effective Date") immediately prior to the effectiveness of the Reincorporation Merger. All references to the number of type of shares under the Plan, including but not limited to (x) the maximum number of shares reserved for issuance under the Plan, including annual increases under Section 3(c) and limits on Restricted Stock Awards and Stock Bonus Awards under Section 3(a), and the maximum number of shares of Stock that may be issued to a person under Section 4, shall be adjusted to take into account changes in capital structure due to the Reincorporation Merger as provided under Section 10(a). Notwithstanding the effectiveness of the Reincorporation Merger, the Committee may only grant Awards on or after the Company's Initial Public Offering.

SECTION 15. GOVERNING LAW; CONSENT TO JURISDICTION

This Plan and all Awards and actions taken thereunder shall be governed by the laws of the State of California applied without regard to the conflict of laws principles thereof. Any action, suit or proceeding to enforce the terms and provisions of this Plan or to resolve any dispute or controversy arising under or in any way relating to this Plan may be brought in the state courts of the State of California and the parties hereto hereby consent to the jurisdiction of such courts.

ADOPTED BY THE BOARD OF DIRECTORS: July 25, 2002

APPROVED BY THE STOCKHOLDERS: July 31, 2002

EXHIBIT 10.14

MOLINA HEALTHCARE, INC.

2002 EMPLOYEE STOCK PURCHASE PLAN

1. Establishment of Plan. Molina Healthcare, Inc. (the "Company") proposes to grant options to purchase shares of the Company's common stock, $0.001 par value per share (the "Common Stock"), to eligible employees of the Company and its Participating Affiliates (as defined below) pursuant to this Employee Stock Purchase Plan (this "Plan"). For purposes of this Plan, "Parent Corporation" and "Subsidiary Corporation" shall have the same meanings as "parent corporation" and "subsidiary corporation" in Sections 424(e) and 424(f), respectively, of the Internal Revenue Code of 1986, as amended (the "Code"). "Participating Affiliates" are Parent Corporations or Subsidiary Corporations that the Board of Directors of the Company (the "Board") designates from time to time as corporations that shall participate in this Plan. Affiliates may be designated as Participating Affiliates either before or after this Plan is approved by the Company's stockholders as provided in Section 22. The Company intends this Plan to qualify as an "employee stock purchase plan" under Section 423 of the Code (including any amendments to or replacements of such Section), and this Plan shall be so construed. Any term not expressly defined in this Plan but defined for purposes of Section 423 of the Code shall have the same definition herein. A total of 15,000 shares of the Common Stock are reserved for issuance under this Plan. As of the last day of each fiscal year of the Company, the number of shares of Common Stock reserved for issuance under the Plan shall be increased by one percent of the issued and outstanding shares of Common Stock immediately after the end of such fiscal year, but in no event shall the total number of shares of Common Stock reserved for issuance exceed 55,000 shares. For purposes of clarification, all references to the number of shares reserved for issuance hereunder shall be construed to refer to the number of shares of the Company prior to the effectiveness of the merger contemplated by that certain Agreement of Merger between the Company and Molina Healthcare, Inc., a Delaware corporation, as amended (the "Reincorporation Merger").

2. Purpose. The purpose of this Plan is to provide eligible employees of the Company and Participating Affiliates with a convenient means of acquiring an equity interest in the Company through payroll deductions, to enhance such employees' sense of participation in the affairs of the Company and Participating Affiliates, and to provide an incentive for continued employment.

3. Administration

(a) This Plan shall be administered by the Compensation Committee of the Board (the "Committee"). Subject to the provisions of this Plan and the limitations of Section 423 of the Code or any successor provision in the Code, all questions of interpretation or application of this Plan shall be determined by the Committee in its sole discretion and its decisions shall be final and binding upon all participants. Members of the Committee shall receive no compensation for their services in connection with the administration of this Plan, other than standard fees as established from time to time by the

Board for services rendered by Board members serving on Board committees. All expenses incurred in connection with the administration of this Plan shall be paid by the Company.

(b) The Committee may, from time to time, consistent with the Plan and the requirements of Section 423 of the Code, establish, change or terminate such rules, guidelines, policies, procedures, limitations, or adjustments as deemed advisable by the Company, in its sole discretion, for the proper administration of the Plan, including, without limitation: (a) a minimum payroll deduction amount required for participation in an Offering Period, (b) a limitation on the frequency or number of changes permitted in the rate of payroll deduction during an Offering Period, (c) a payroll deduction greater or less than the amount designated by a participant in order to adjust for the Company's delay or mistake in processing an Enrollment Form or in otherwise effecting a participant's election under the Plan or as advisable to comply with the requirements of Section 423 of the Code, (d) determination of the date and manner by which the Fair Market Value of the Common Stock is determined for purposes of administration of the Plan, (e) delegate responsibility for Plan operation, management and administration, subject to the Committee's oversight and control, on such terms as the Committee may establish, and (f) delegate to other persons the responsibility for performing appropriate functions as necessary, desirable or appropriate to further the purposes of this Plan.

4. Eligibility. Any individual employed by the Company or the Participating Affiliates on the "Offering Date" of an "Offering Period" (each as defined in Section 5 below) is eligible to participate in such Offering Period except the following:

(a) employees who are customarily employed for twenty (20) hours or less per week; and

(b) employees who, together with any other person whose stock would be attributed to such employee pursuant to Section 424(d) of the Code, own stock or hold options to purchase stock possessing five percent (5%) or more of the total combined voting power or value of all classes of stock of the Company or any of its Participating Affiliates or who, as a result of being granted an option under this Plan with respect to such Offering Period, would own stock or hold options to purchase stock possessing five percent (5%) or more of the total combined power or value of all classes of stock of the Company or any of its Participating Affiliates; and

(c) individuals who provide services to the Company or any of its Participating Affiliates as independent contractors who are reclassified as common law employees for any reason except for federal income and employment tax purposes.

5. Offering Periods. The offering periods of this Plan (each, an "Offering Period") shall be of six (6) months duration commencing on January 1 and July 1 of the Company's fiscal year; provided, however, that the first such Offering Period shall commence on the date (the "IPO Date") of the first fully underwritten, firm commitment public offering pursuant to an effective registration statement under the Securities Act of 1933, as amended, other than on Forms S-4 or S-8 or their then equivalents, covering the

offer and sale by the Company of its equity securities or such other events as a result of or following which the Common Stock shall be publicly held (the "Initial Public Offering") and shall end on December 31, 2003 (the "First Offering Period"). The first day of each Offering Period is referred to as the "Offering Date." The last day of each Offering Period is referred to as the "Purchase Date." The Committee shall have the power to change the Offering Dates or Purchase Dates and the duration of Offering Periods without stockholder approval if such change is announced prior to the start of the relevant Offering Period, or prior to such other time period as specified by the Committee; provided, however, that no Offering Period may have a duration exceeding twenty-seven (27) months. If the first or last day of an Offering Period is not a day on which the New York Stock Exchange is open for trading, the Company shall specify the trading day that will be deemed the first or last day, as the case may be, of the Offering Period.

6. Participation in this Plan. An employee may participate during an Offering Period on the first Offering Date after such employee satisfies the eligibility requirements set forth in Section 4 above and delivers an enrollment form in substantially the form attached hereto as Exhibit A (the "Enrollment Form") to the Company prior to such Offering Date, or such other time period as specified by the Committee; provided, however, that: the Company will automatically enroll on the IPO Date all employees eligible to participate in the Plan as determined under Section 4 as of such date, and such eligible employees shall be deemed to have completed an Enrollment Form specifying a contribution rate to the Plan equal to ten percent (10%) of each such employee's "Compensation" (as defined in Section 9 below). Notwithstanding the foregoing, the Committee may set a later time for filing the Enrollment Form authorizing payroll deductions for all eligible employees with respect to a given Offering Period. An eligible employee who does not timely deliver an Enrollment Form to the Company after becoming eligible to participate in such Offering Period shall not participate in that Offering Period or any subsequent Offering Period until filing an Enrollment Form with the Company prior to the applicable Offering Date, or such other time period as specified by the Committee. Once an employee becomes a participant in an Offering Period, such employee will automatically participate in the Offering Period commencing immediately following the last day of the prior Offering Period unless the employee withdraws or is deemed to withdraw from this Plan or terminates further participation in the Offering Period as set forth in Section 11 below. A participant who has not otherwise withdrawn from this Plan under Section 11 is not required to file any additional Enrollment Form in order to continue participation in this Plan. However a participant may deliver a new Enrollment Form for a subsequent Offering Period in accordance with the procedures set forth in this Section 6 if the participant wishes to change any of the elections contained in the participant's then effective Enrollment Form.

7. Grant of Option on Enrollment. Enrollment by an eligible employee in an Offering Period under this Plan will constitute the grant (as of the Offering Date for such Offering Period) by the Company to such employee of an option to purchase on the Purchase Date up to that number of shares of Common Stock of the Company determined by dividing (a) the amount accumulated in such employee's payroll deduction account during such Offering Period (or, if applicable for those employees participating in the First Offering Period, the amount of the lump sum cash payment required to purchase shares

pursuant to Sections 6 and 9) by (b) the Per Share Purchase Price as determined pursuant to Section 8 below (but in no event less than the par value of a share of Company's Common Stock), provided, however, that the number of shares of the Company's Common Stock subject to any option granted pursuant to this Plan shall not exceed the maximum number of shares which may be purchased pursuant to Section 10 below with respect to the applicable Purchase Date. The Fair Market Value of a share of the Company's Common Stock shall be determined as provided in Section 8 below.

8. Purchase Price. The purchase price per share ("Per Share Purchase Price") at which a share of Common Stock will be sold in any Offering Period shall be eighty-five percent (85%) of the lesser of:

(a) The Fair Market Value on the Offering Date; or

(b) The Fair Market Value on the Purchase Date.

For purposes of this Plan, the term "Fair Market Value" of the Common Stock on any given date means (i) the last reported closing price for a share of Stock on the New York Stock Exchange or, (ii) in the absence of reported sales on the New York Stock Exchange on a given date, the closing price of the New York Stock Exchange on the last date on which a sale occurred prior to such date; or (iii) if the stock is no longer publicly traded on the New York Stock Exchange, the Committee in good faith shall determine Fair Market Value; provided that, if the date for which the Fair Market Value is determined is the first day when trading prices for the Stock are reported on the New York Stock Exchange, the Fair Market Value shall be the public offering price set forth on the cover page for the final prospectus relating to the Company's Initial Public Offering.

9. Payment of Purchase Price; Changes in Payroll Deductions; Issuance of Shares.

(a) The purchase price of the shares shall be accumulated by regular payroll deductions made during each Offering Period; provided, however, that the purchase price of the shares for the First Offering Period shall be paid by the participant in a lump sum cash payment on such Offering Period's Purchase Date (unless the participant makes an election to commence payroll deductions pursuant to Section 9(b) below). The deductions are made as a percentage of the participant's Compensation in one percent (1%) increments not less than one percent (1%) (except as a result of an election pursuant to Section 9(c) to stop payroll deductions during an Offering Period), nor greater than fifteen percent (15%) or such lower limit set by the Committee. "Compensation" shall mean all W-2 cash compensation, including base salary, wages, commissions, overtime, shift premiums and bonuses, provided, however, that for purposes of determining a participant's compensation, any election by such participant to reduce his or her regular cash remuneration under Sections 125 or 401(k) of the Code shall be treated as if the participant did not make such election. Notwithstanding the foregoing, Compensation shall not include reimbursements of expenses, allowances, long-term disability, workers' compensation or any amount deemed received without the actual transfer of cash or any amounts directly or indirectly paid pursuant to the Plan or any other stock purchase or stock option plan, or any other compensation not included above. Payroll deductions shall

commence on the first payday of the Offering Period and shall continue to the end of the Offering Period unless sooner altered or terminated as provided in this Plan; provided, however, that payroll deductions for the First Offering Period shall only commence if the participant makes an election pursuant to Section 9(b) below.

(b) A participant may increase or decrease the rate of payroll deductions during an Offering Period by filing with the Company a new Enrollment Form, in which case the new rate shall become effective for the next payroll period commencing after the Company's receipt of the Enrollment Form and shall continue for the remainder of the Offering Period unless changed as described below. Such change in the rate of payroll deductions may be made at any time during an Offering Period, but not more than one (1) change may be made effective during any Offering Period. A participant may increase or decrease the rate of payroll deductions for any subsequent Offering Period by filing with the Company a new Enrollment Form prior to the beginning of such Offering Period, or prior to such other time period as specified by the Committee. Additionally, and notwithstanding the foregoing, during the First Offering Period, a participant may only elect to have the purchase price of the shares accumulated by regular payroll deductions by filing with the Company an Enrollment Form after the IPO Date and on or before December 31, 2003.

(c) A participant may reduce his or her payroll deduction percentage to zero during an Offering Period by filing with the Company a revised Enrollment Form. Such reduction shall be effective beginning with the next payroll period after the Company's receipt of the request and no further payroll deductions will be made for the duration of the Offering Period. Payroll deductions credited to the participant's account prior to the effective date of the request shall be used to purchase shares of Common Stock in accordance with Section (e) below. A participant may not resume making payroll deductions during the Offering Period in which he or she reduced his or her payroll deductions to zero.

(d) All payroll deductions made for a participant are credited to his or her account under this Plan and are deposited with the general funds of the Company. No interest accrues on the payroll deductions. All payroll deductions received or held by the Company may be used by the Company for any corporate purpose, and the Company shall not be obligated to segregate such payroll deductions.

(e) On each Purchase Date, so long as this Plan remains in effect and provided that the participant has not submitted a revised Enrollment Form withdrawing from the Plan before such Purchase Date in accordance with Section 11, the Company shall apply the funds then in the participant's account (or, if applicable, the lump sum cash payment received from the participant) to the purchase of whole shares of Common Stock reserved under the option granted to such participant with respect to the Offering Period to the extent that such option is exercisable on the Purchase Date. The Per Share Purchase Price shall be as specified in Section 8. Any cash remaining in such participant's account on a Purchase Date which is less than the amount necessary to purchase a full share of Common Stock of the Company shall be carried forward, without interest, into the next Offering Period. If this Plan has been oversubscribed, all funds not used to purchase

shares on the Purchase Date shall be returned to the participant, without interest. No Common Stock shall be purchased on a Purchase Date on behalf of any employee whose participation in this Plan has terminated prior to such Purchase Date.

(f) As promptly as practicable after the Purchase Date, the Company shall issue shares for the participant's benefit representing the shares purchased upon exercise of his or her option, subject to compliance with Section 24 below.

(g) During a participant's lifetime, his or her option to purchase shares hereunder is exercisable only by him or her. The participant will have no interest or voting right in shares covered by his or her option until such option has been exercised.

10. Limitations on Shares to be Purchased.

(a) No participant shall be entitled to purchase Common Stock under this Plan at a rate which, when aggregated with his or her rights to purchase stock under all other employee stock purchase plans of the Company or any Parent Corporation or Subsidiary Corporation, exceeds $25,000 in Fair Market Value, determined as of the Offering Date (or such other limit as may be imposed by the Code) for each calendar year in which the employee participates in this Plan. The Company shall automatically suspend the payroll deductions of any participant as necessary to enforce such limit; provided that when the Company automatically resumes such payroll deductions, the Company must apply the rate in effect immediately prior to such suspension.

(b) No participant shall be entitled to purchase more than the Maximum Share Amount (as defined below) on any single Purchase Date. Prior to the commencement of any Offering Period or before such time period as specified by the Committee, the Committee may, in its sole discretion, set a maximum number of shares which may be purchased by any employee at any single Purchase Date (the "Maximum Share Amount"). Until otherwise determined by the Committee, there shall be no Maximum Share Amount. If a new Maximum Share Amount is set, then all participants must be notified of such Maximum Share Amount before commencing the next Offering Period. The Maximum Share Amount shall continue to apply with respect to all succeeding Purchase Dates and Offering Periods unless revised by the Committee as set forth above.

(c) If the number of shares to be purchased on a Purchase Date by all employees participating in this Plan exceeds the number of shares then available for issuance under this Plan, then the Company will make a pro rata allocation of the remaining shares in as uniform a manner as shall be reasonably practicable and as the Committee shall determine to be equitable.

(d) Any payroll deductions accumulated in a participant's account which are not used to purchase stock due to the limitations in this Section 10 shall be returned to the participant as soon as practicable after the end of the applicable Offering Period, without interest, provided that, any amount remaining in such participant's account which is less than the amount necessary to purchase a full share of Common Stock of the

Company shall be carried forward, without interest, into the next Offering Period or Offering Period.

11. Withdrawal.

(a) Each participant may withdraw from an Offering Period under this Plan by signing and delivering to the Company a revised Enrollment Form indicating such participant's intention to withdraw. Such withdrawal may be elected at any time prior to the end of an Offering Period, or such other time period as specified by the Committee.

(b) Upon withdrawal from this Plan, the accumulated payroll deductions shall be returned to the withdrawn participant, without interest, and his or her interest in this Plan shall terminate. If a participant voluntarily elects to withdraw from this Plan, he or she may not resume his or her participation in this Plan during the same Offering Period, but he or she may participate in any Offering Period under this Plan commencing after such withdrawal by filing a new authorization for payroll deductions in the same manner as set forth in Section 6 above for initial participation in this Plan.

12. Termination of Employment. Termination of a participant's employment for any reason, including retirement, death or the failure of a participant to remain an eligible employee of the Company or of a Participating Affiliate, immediately terminates his or her participation in this Plan. In such event, the payroll deductions credited to the participant's account will be returned to him or her or, in the case of his or her death, to his or her legal representative, without interest. For purposes of this Section 12, an employee will not be deemed to have terminated employment or failed to remain in the continuous employ of the Company or of a Participating Affiliate in the case of sick leave, military leave, or any other leave of absence approved by the Board; provided that such leave is for a period of not more than ninety (90) days or reemployment upon the expiration of such leave is guaranteed by contract or statute.

13. Return of Payroll Deductions. If a participant's interest in this Plan is terminated by withdrawal, termination of employment or otherwise, or if this Plan is terminated by the Board, the Company shall deliver to the participant all payroll deductions credited to such participant's account. No interest shall accrue on the payroll deductions of a participant in this Plan.

14. Capital Changes. Subject to any required action by the stockholders of the Company, the number of shares of Common Stock covered by each option under this Plan which has not yet been exercised and the number of shares of Common Stock which have been authorized for issuance under this Plan but have not yet been placed under option (collectively, the "Reserves"), as well as the price per share of Common Stock covered by each option under this Plan which has not yet been exercised, shall be proportionately adjusted for any increase or decrease in the number of issued and outstanding shares of Common Stock resulting from a stock split or the payment of a stock dividend (but only on the Common Stock) or any other increase or decrease in the number of issued and outstanding shares of Common Stock effected without receipt of any consideration by the Company; provided, however, that conversion of any convertible securities of the

Company shall not be deemed to have been "effected without receipt of consideration". Notwithstanding the foregoing, any fractional shares resulting from an adjustment pursuant to this Section 14 shall be rounded down to the nearest whole number, and in no event may the Per Share Purchase Price be decreased to an amount less than the par value, if any, of the Common Stock. Such adjustment shall be made by the Committee, whose determination shall be final, binding and conclusive. Notwithstanding the foregoing, the required adjustment under this Section 14 in connection with the effectiveness of the Reincorporation Merger shall be consistent with the adjustment made to all then outstanding shares of the Common Stock of the Company.

In the event of the proposed dissolution or liquidation of the Company, the Offering Period will terminate immediately prior to the consummation of such proposed action, unless otherwise provided by the Committee. The Committee may, in its sole discretion in such instances, declare that this Plan shall terminate as of a date fixed by the Committee and either give each participant the right to purchase shares under this Plan prior to such termination or return all accumulated payroll deductions to each participant, without interest. In the event of (i) a merger or consolidation in which the Company is not the surviving corporation (other than a merger or consolidation with a wholly-owned subsidiary, a reincorporation of the Company in a different jurisdiction (including pursuant to the Reincorporation Merger), or other transaction in which there is no substantial change in the stockholders of the Company or their relative stock holdings, provided that the options under this Plan are assumed, converted or replaced by the successor corporation, which assumption will be binding on all participants), (ii) a merger in which the Company is the surviving corporation but after which the stockholders of the Company immediately prior to such merger (other than any stockholder that merges, or which owns or controls another corporation that merges, with the Company in such merger) cease to own their shares or other equity interest in the Company, (iii) the sale of all or substantially all of the assets of the Company or (iv) the acquisition, sale, or transfer of more than 50% of the outstanding shares of the Company by tender offer or similar transaction, (each a "Sale Event") the Company shall apply the funds contributed under the Plan to the purchase of shares of Common Stock pursuant to the provisions of Section 9 immediately prior to the effective date of such Sale Event. Notwithstanding the foregoing, the surviving, continuing, successor or purchasing corporation or parent corporation thereof (the "Acquiring Corporation"), may elect to assume the Company's rights and obligations under the Plan and, in that event, there shall be no purchase before the end of the Offering Period in which the Sale Event occurs.

The Committee may, if it so determines in its sole discretion, also make provision for adjusting the share reserve set forth in Section 1, as well as the price per share of Common Stock covered by each outstanding option, solely in the event that the Company effects one or more reorganizations, recapitalizations, rights offerings or other increases or reductions of shares of its outstanding Common Stock, or in the event of the Company being consolidated with or merged into any other corporation; provided, however, that upon the effectiveness of the Reincorporation Merger, the number of shares set forth in Section 1 shall be automatically adjusted on the same basis as each outstanding share of the Common Stock of the Company immediately prior to the effect of the Reincorporation Merger.

15. Withholding. The participant shall make adequate provision for the foreign, federal, state and local tax withholding obligations of the Company or any of its Participating Affiliates, if any, which arise in connection with participation in the Plan. The Company and its Participating Affiliates shall, to the extent permitted by law, have the right to deduct any such taxes from any payment of any kind otherwise due to the participant.

16. Nonassignability. Neither payroll deductions credited to a participant's account nor any rights with regard to the exercise of an option or to receive shares under this Plan may be assigned, transferred, pledged or otherwise disposed of in any way (other than by will, the laws of descent and distribution or as provided in Section 23 below) by the participant. Any such attempt at assignment, transfer, pledge or other disposition shall be void and without effect.

17. Reports. Individual accounts will be maintained for each participant in this Plan. Each participant shall receive as soon as practicable after the end of each Offering Period a report of his or her account setting forth the total payroll deductions accumulated, the number of shares purchased, the per share price thereof and the remaining cash balance, if any, carried forward to the next Offering Period.

18. Notice of Disqualifying Disposition. Each participant shall notify the Company in writing if the participant disposes of any of the shares purchased in any Offering Period pursuant to this Plan if such disposition occurs within two (2) years from the Offering Date or within one (1) year from the Purchase Date on which such shares were purchased (the "Notice Period"). The Company may, at any time during the Notice Period, place a legend or legends on any certificate representing shares acquired pursuant to this Plan requesting the Company's transfer agent to notify the Company of any transfer of the shares. The obligation of the participant to provide such notice shall continue notwithstanding the placement of any such legend on the certificates.

19. No Rights as Stockholder or to Continued Employment. A participant shall have no rights as a stockholder by virtue of participation in the Plan until the date of the issuance of a certificate for the shares purchased pursuant to the exercise of the participant's purchase right (as evidenced by the appropriate entry on the books of the Company or of a duly authorized transfer agent of the Company). No adjustment shall be made for dividends, distributions or other rights for which the record date is prior to the date such certificate is issued, except as provided in Section 14. Neither this Plan nor the grant of any option hereunder shall confer any right on any employee to remain in the employ of the Company or any Participating Affiliate, or restrict the right of the Company or any Participating Affiliate to terminate such employee's employment at any time.

20. Equal Rights and Privileges. All eligible employees shall have equal rights and privileges with respect to this Plan so that this Plan qualifies as an "employee stock purchase plan" within the meaning of Section 423 or any successor provision of the Code and the related regulations. Any provision of this Plan which is inconsistent with Section 423 or any successor provision of the Code shall, without further act or amendment by the

Company, the Committee or the Board, be reformed to comply with the requirements of Section 423. This Section 20 shall take precedence over all other provisions in this Plan.

21. Notices. All notices or other communications by a participant to the Company under or in connection with this Plan shall be deemed to have been duly given when received in the form specified by the Company at the location, or by the person, designated by the Company for the receipt thereof.

22. Term; Stockholder Approval. This plan shall be effective on the date (the "Effective Date") immediately prior to effectiveness of the Reincorporation Merger. All references to the number or type of shares reserved for issuance under the Plan shall be adjusted to take into account changes in the Company's capital structure due to the Reincorporation Merger as provided under Section 14. Notwithstanding the effectiveness of the Reincorporation Merger, no Offering Period may commence before the IPO Date. This Plan shall continue until the earlier to occur of (a) termination of this Plan by the Board (which termination may be effected by the Board at any time), (b) issuance of all of the shares of Common Stock reserved for issuance under this Plan, or (c) July 24, 2012.

23. Designation of Beneficiary

(a) A participant may file a written designation of a beneficiary who is to receive any shares and cash, if any, from the participant's account under this Plan in the event of such participant's death subsequent to the end of any Offering Period but prior to delivery to him of such shares and cash. In addition, a participant may file a written designation of a beneficiary who is to receive any cash from the participant's account under this Plan in the event of such participant's death prior to a Purchase Date.

(b) Such designation of beneficiary may be changed by the participant at any time by written notice. In the event of the death of a participant and in the absence of a beneficiary validly designated under this Plan who is living at the time of such participant's death, the Company shall deliver such shares or cash to the executor or administrator of the estate of the participant, or if no such executor or administrator has been appointed (to the knowledge of the Company), the Company, in its discretion, may deliver such shares or cash to the spouse or to any one or more dependents or relatives of the participant, or if no spouse, dependent or relative is known to the Company, then to such other person as the Company may designate.

24. Conditions Upon Issuance of Shares; Limitation on Sale of Shares. Shares shall not be issued with respect to an option unless the exercise of such option and the issuance and delivery of such shares pursuant thereto shall comply with all applicable provisions of law, domestic or foreign, including, without limitation, the Securities Act of 1933, as amended, the Securities Exchange Act of 1934, as amended, the rules and regulations promulgated thereunder, and the requirements of any stock exchange or automated quotation system upon which the shares may then be listed, and shall be further subject to the approval of counsel for the Company with respect to such compliance.

25. Applicable Law. The Plan shall be governed by the substantive laws (excluding the conflict of laws rules) of the State of California.

26. Amendment or Termination of this Plan. The Board may at any time amend, terminate or extend the term of this Plan, except that (i) any such termination cannot affect options previously granted under this Plan unless the Board determines that the termination of the Plan immediately following any Purchase Date is in the best interests of the Company and its stockholders, (ii) any amendment may not adversely affect the previously granted purchase right of any participant unless permitted by the Plan or as may be necessary to qualify the Plan as an employee stock purchase plan pursuant to Section 423 of the Code or to obtain qualification or registration of the Common Stock under applicable federal, state or foreign securities laws, and (iii) any amendment must be approved by the stockholders of the Company in accordance with Section 2 above within twelve (12) months of the adoption of such amendment (or earlier if required by Section 22) if such amendment would:

(a) increase the number of shares that may be issued under this Plan;

(b) change the designation of the employees (or class of employees) eligible for participation in this Plan; or

(c) any other action taken by the Board that, by its terms, is contingent on stockholder approval.

Notwithstanding the foregoing, the Board may make such amendments to the Plan as the Board determines to be advisable, if the continuation of the Plan or any Offering Period would result in financial accounting treatment for the Plan that is different from the financial accounting treatment in effect on July 23, 2002.

Exhibit 21.1

List of Subsidiaries

Molina Healthcare of California, a California corporation.

Molina Healthcare of Washington, Inc., a Washington corporation.

Molina Healthcare of Michigan, Inc., a Michigan corporation.

Molina Healthcare of Utah, Inc., a Utah corporation.

Molina Advantage, Inc., a Utah corporation.

Exhibit 23.1

CONSENT OF ERNST & YOUNG LLP, INDEPENDENT AUDITORS

We consent to the reference to our firm under the caption “Experts” and to the use of our reports dated March 29, 2002 (except Note 10, as to which the date is , 2003), with respect to the consolidated financial statements of Molina Healthcare, Inc. as of and for the years ended December 31, 2000 and 2001, and June 21, 2002, with respect to the statements of income and comprehensive income and cash flows of QualMed Washington Health Plan, Inc. for the year ended December 31, 1999, included in the Registration Statement (Form S-1 No. 33-) and related Prospectus of Molina Healthcare, Inc. for the registration of shares of its common stock.

ERNST & YOUNG LLP

Los Angeles, California
, 2003

The foregoing consent is in the form that will be signed upon the completion of the restatement of capital accounts described in Note 10 to the consolidated financial statements.

/s/ ERNST & YOUNG LLP

Los Angeles, California
December 23, 2002