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As filed with the Securities and Exchange Commission on April 11, 2003.

Registration No. 333-102268

SECURITIES AND EXCHANGE COMMISSION

WASHINGTON, D.C. 20549

Amendment No. 2
to
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**	**13-4204626**
(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(2)

(1) Estimated solely for the purpose of calculating the registration fee pursuant to rule 457(a) of the Securities Act of 1933.
(2) Previously paid with the initial filing.

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.

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.

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

SG Cowen

, 2003

[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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PROSPECTUS SUMMARY

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 $644.2 million in 2002, while our net income grew from $2.6 million to $30.5 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 control administrative costs. As of December 31, 2002, we had approximately 489,000 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 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 the Centers for Medicare and Medicaid Services. All states in which we operate have mandated Medicaid managed care programs in place.

Our Approach

We have built a successful Medicaid managed care company by integrating those capabilities that we believe have allowed us to compete in our industry. Our approach to managed care is based on the following key attributes:

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
- maximize 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 repayment of amounts borrowed under our credit facility, 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 December 31, 2002. This information excludes:

- 416,680 shares of common stock issuable upon the exercise of vested stock options with a weighted average exercise price of $2.87 per share,
- 341,680 shares of common stock issuable upon the exercise of unvested stock options with a weighted average exercise price of $4.44 per share,
- 1,600,000 shares of common stock reserved for issuance under our stock option plans, and
- 600,000 shares of common stock reserved for issuance under the 2002 Employee Stock Purchase Plan.

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.

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,		
	2000	2001	2002
	(dollars in thousands, except per share data)		
Statements of Income Data:			
Revenue:			
Premium revenue	$ 324,300	$ 499,471	$ 639,295
Other operating revenue	1,971	1,402	2,884
Investment income	3,161	2,982	1,982
Total operating revenue	329,432	503,855	644,161
Expenses:			
Medical care costs	264,408	408,410	530,018
Marketing, general and administrative expenses (including a charge for stock option settlements of $7,796 in 2002)	38,701	42,822	61,227
Deprecation and amortization	2,085	2,407	4,112
Total expenses	305,194	453,639	595,357
Operating income	24,238	50,216	48,804
Total other expense, net	(197)	(561)	(405)
Income before income taxes	24,041	49,655	48,399
Provision for income taxes	9,156	19,453	17,891
Income before minority interest	14,885	30,202	30,508
Minority interest	79	(73)	—
Net income	14,964	30,129	30,508
Basic net income per share			
Actual	0.75	1.51	1.53
Pro forma (1)	—	—	1.60
Diluted net income per share			
Actual	0.73	1.46	1.48
Pro forma (1)	—	—	1.55
Cash dividends declared per share	0.05	—	—
Weighted average number of common shares outstanding	20,000,000	20,000,000	20,000,000
Weighted average number of common shares and potential dilutive common shares outstanding	20,376,000	20,572,000	20,609,000
Operating Statistics:			
Medical care ratio (2)	81.0%	81.5%	82.5%
Marketing, general and administrative expense ratio (3)	11.7%	8.5%	9.5%
Members (4)	298,000	405,000	489,000

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	As of December 31,				
	2000	2001	2002	2002 Pro Forma(1)	2002 Pro Forma As Adjusted(5)
	(dollars in thousands)				
Balance Sheet Data:					
Cash and cash equivalents	$ 45,785	$ 102,750	$ 139,300	$ 123,910	$
Total assets	102,012	149,620	204,966	189,576	
Long-term debt (including current maturities)	3,448	3,401	3,350	8,350	
Total liabilities	67,405	84,861	109,699	114,699	
Stockholders' equity	34,607	64,759	95,267	74,877	

(1) The pro forma basic and diluted net income per share for the year ended December 31, 2002 and the pro forma balance sheet data as of December 31, 2002, give effect to the redemptions of 1,201,174 shares of common stock in January and February 2003 for cash payments of $20,390 and borrowing in March 2003 under the credit facility of $5,000. The pro forma basic and diluted net income per share reflect the redemptions and borrowing as occurring on January 1, 2002, and assume reduced investment income, increased interest expense, and reduced income taxes and net income. The pro forma balance sheet data reflect the redemptions and borrowing as occurring on December 31, 2002. See Note 12 to the Audited Consolidated Financial Statements.

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

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

(4) Number of members at end of period.

(5) The pro forma as adjusted data give effect to the redemptions of shares of common stock and borrowing under the credit facility (see (1) above) and 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 Our Business

Reductions in Medicaid funding could substantially reduce our profitability.

Substantially all of our revenues come from state Medicaid premiums. The premium rates paid by each state to health plans like ours differ depending on a combination of factors such as upper payment limits established by the 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 in or eligible for Medicaid, reduce the amount of reimbursement or payment levels by the governments or increase our administrative or health benefit costs. Additionally, changes could eliminate coverage for certain benefits such as our pharmacy, behavioral health or other benefits. In some cases, changes in funding could be made retroactive. Reductions in Medicaid payments could reduce our profitability if we are unable to reduce our expenses.

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

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

If we 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, our medical care costs as a percentage of premium and other operating revenue have fluctuated. Relatively small changes in these medical care ratios can create significant changes in our financial results. Changes in health care laws, regulations and practices, level of use of health care services, hospital costs,

pharmaceutical costs, major epidemics, terrorism or bioterrorism, new medical technologies and other external factors, including general economic conditions such as inflation levels, could reduce our ability to predict and effectively control the costs of providing health care services. Although we have been able to manage medical care costs through a variety of techniques, including various payment methods to primary care physicians and other providers, advance approval for hospital services and referral requirements, medical management and quality management programs, our information systems, and reinsurance arrangements, we may not be able to continue to effectively manage medical care costs in the future. If our medical care costs increase, our profits could be reduced or we may not remain profitable.

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

Our medical care costs include estimates of claims incurred but not reported. We, together with our independent actuaries, estimate our medical claims liabilities using actuarial methods based on historical data adjusted for payment patterns, cost trends, product mix, seasonality, utilization of health care services and other relevant factors. The estimation methods and the resulting reserves are continually reviewed and updated, and adjustments, if necessary, are reflected in the period known. While our estimates of claims incurred but not reported have been adequate in the past, they may be inadequate in the future, which would negatively affect our results of operations. Further, our inability to accurately estimate claims incurred but not reported may also affect our ability to take timely corrective actions, further exacerbating the extent of the negative impact on our results. If we estimate claims incurred but not reported too conservatively, we understate our profits, which could result in inaccurate disclosure to the public in our periodic reports.

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

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

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

For example, Congress enacted the Health Insurance Portability and Accountability Act of 1996 which mandates that health plans enhance privacy protections for member protected health information. This requires health plans to add, at significant cost, new administrative, information and security systems to prevent inappropriate release of protected member health information. Compliance with this law is uncertain and has and will continue to affect our profitability. Similarly, individual states periodically consider adding operational requirements applicable to health plans, often without identifying funding for these requirements. California recently required all health plans to make available to members independent medical review of their claims. This requirement is costly to implement and could affect our profitability.

We are subject to various routine and non-routine governmental reviews, audits and investigation. Violation of the laws governing our operations, or changes in interpretations of those laws, could result in the imposition of civil or criminal penalties, the cancellation of our contracts to provide managed care services, the suspension or revocation of our licenses, and exclusion from participation in government sponsored health programs, including Medicaid and the State Children's Health Insurance Program. If we become subject to material fines or if other sanctions or other corrective actions were imposed upon us, we might suffer a substantial reduction in profitability, and might also lose one or more of our government contracts and as a result lose significant numbers of members and amounts of revenue. In 1998, one of our health plans sent letters to certain plan members notifying them of a pending program change and the need to reselect their current primary care physician if they intended to stay with that physician. The state regulatory agency contended that the letters violated state and federal marketing laws and the health plan's government contract. Our health plan agreed to pay a $6,000 penalty as well as a limited suspension of enrollment and marketing activities for sixty days. Later, the Office of Inspector General asserted jurisdiction over the matter, and the health plan agreed to pay an additional $600,000 penalty.

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

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

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

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

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

The acquisitions of Medicaid contract rights and other health plans have accounted for a significant amount of our growth. Although we cannot predict with certainty our rate of growth as the result of acquisitions, we

believe that acquisitions similar in nature to those we have historically executed will be important to our future growth strategy. Many of the other potential purchasers of these assets have greater financial resources than we have. Also, many of the sellers may insist on selling assets that we do not want, such as commercial lines of business, or may insist on transferring their liabilities to us as part of the sale of their companies or assets. Even if we identify suitable targets, we may be unable to complete acquisitions on terms favorable to us or obtain the necessary financing for these acquisitions. Further, to the extent we complete 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. This may include the integration of:

- additional employees who are not familiar with our operations,
- new provider networks, which may operate on terms different from our existing networks,
- additional members, who may decide to transfer to other health care providers or health plans,
- disparate information, claims processing and record keeping systems, and
- accounting policies, including those which require judgmental and complex estimation processes, such as estimates of claims incurred but not reported, accounting for goodwill, intangible assets, stock-based compensation and income tax matters.

Also, we are generally required to obtain regulatory approval from one or more state agencies when making acquisitions. 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. For all of the above reasons, we may not be able to sustain our pattern of growth.

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

Depending on acquisition and other opportunities, we expect to continue to grow our membership and to expand into other markets. In 1998, we had total revenue of $135.9 million. In 2002, we had total revenue of $644.2 million. Continued rapid growth could place a significant strain on our management and on other resources. Our ability to manage our growth may depend on our ability to strengthen our management team and attract, train and retain skilled employees, and our ability to implement and improve operational, financial and management information systems on a timely basis. If we are unable to manage our growth effectively, our financial condition and results of operations could be materially and adversely affected. In addition, due to the initial substantial costs related to acquisitions, rapid growth could adversely affect our short-term profitability and liquidity.

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

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

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

We secured a $75.0 million credit facility 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. Our credit facility documents contain customary restrictions and covenants that may restrict our financial and operating flexibility, including our ability to declare dividends.

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 which could negatively impact our operations.

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

Our providers involved in medical care decisions may be exposed to the risk of medical malpractice claims. Providers at the primary care clinics we operate in California are employees of our California subsidiary. As a direct employer of physicians and ancillary medical personnel and as an operator of primary care clinics, our subsidiary may experience increased exposure to liability for acts or omissions by our employees and for acts or injuries occurring on our premises. We maintain errors and omissions insurance in the amount of $5 million per occurrence and in aggregate for each policy year, medical malpractice insurance for our clinics in the amount of $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.

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

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

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

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

We principally operate through our health plan subsidiaries. These subsidiaries are subject to laws and regulations that limit the amount of dividends and distributions that they can pay to us without prior approval of, or notification to, state regulators. 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.

Risks Associated With This Offering

There has been no public market, and it is possible that no 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 health maintenance organizations and other managed care organizations,
- government action regarding eligibility,
- changes in government payment levels,
- changes in state mandatory programs,
- changes in expectations as to our future financial performance or changes in financial estimates, if any, of public market analysts,
- announcements relating to our business or the business of our competitors,
- conditions generally affecting the managed care industry or our provider networks,
- the success of our operating or acquisition strategy,
- the operating and stock price performance of other comparable companies,
- the termination of our Medicaid or State Children's Health Insurance Program 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 net tangible book value of our assets immediately following the offering (on a pro forma as adjusted basis as of December 31, 2002), after giving effect to the redemptions of 1,201,174 shares of common stock for approximately $20.4 million in January and February 2003, as if the redemptions had occurred on December 31, 2002, 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 December 31, 2002, we had outstanding options to purchase 758,360 shares of our common stock, of which 416,680 were vested. All previously unvested options will vest upon the closing of this offering. From time to time, we may issue additional options to employees and non-employee directors pursuant to our equity incentive plans. These options generally vest commencing one year from the date of grant and continue vesting over a three to five year period. Once these options vest, you will experience further dilution as these stock options are exercised by their holders.

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

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 December 31, 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.

We are subject to the Delaware anti-takeover laws regulating corporate takeovers. These anti-takeover laws prevent Delaware corporations from engaging in business combinations with any stockholder, including all affiliates and associates of the stockholder, who owns 15.0% or more of the corporation's outstanding voting stock, for three years following the date that the stockholder acquired 15.0% or more of the corporation's voting stock unless specified conditions are met, as further described in "Description of Capital Stock."

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

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

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.

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:

- repay amounts borrowed under our credit facility,
- 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.

Borrowings from our $75.0 million credit facility will be used for acquisitions, enrollment initiatives and general corporate purposes. In March 2003, we borrowed $5.0 million under the credit facility. In addition, we anticipate that approximately $20 million of the credit facility will be used to finance the purchase of common stock by our contemplated employee stock ownership plan. The principal amounts borrowed under the credit facility will be due in three years. The interest rate per annum will be (a) LIBOR plus a margin between 225 and 275 basis points or (b) the higher of (i) Bank of America prime or (ii) the federal funds rate plus 0.50%, plus a margin between 125 and 175 basis points. The interest rate margins will be reduced if the proceeds of this offering are in excess of $50 million.

In January and February 2003, we redeemed 1,201,174 shares of our common stock at $16.98 per share from Janet M. Watt, Josephine M. Battiste, the Mary R. Molina Living Trust, the Mary Martha Molina Trust (1995), the Janet M. Watt Trust (1995) and the Josephine M. Molina Trust (1995). These stockholders held a combined interest of 40.0% prior to the redemption, which was reduced to 36.2%. The total cash payment of $20,390,000 was made from available cash reserves. The remainder beneficiaries of the Mary R. Molina Living Trust are J. Mario Molina, M.D., John C. Molina, J.D., M. Martha Bernadett, M.D., Janet M. Watt and Josephine M. Battiste.

DIVIDEND POLICY

We have in the past declared and paid cash dividends on our common stock. There were no dividends declared in 2002, 2001, 1999 or 1998. Dividends in the amount at $1,000,000 were declared in 2000. 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, the terms of our credit facility limit our ability to pay dividends.

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CAPITALIZATION

The following table shows our cash, cash equivalents and capitalization, as of December 31, 2002:

- on an actual basis, unadjusted for any exercise of outstanding options to purchase common stock that were vested at December 31, 2002 and options that would be vested at the closing of the offering,
- on a pro forma basis, giving effect to the redemptions from certain of our stockholders of approximately $20.4 million of our common stock in January and February 2003 using our cash reserves and borrowing of $5.0 million in March 2003 under our credit facility, and
- on a pro forma as adjusted basis to reflect the common stock redemptions and borrowing and the issuance 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.

	December 31, 2002		
	Actual	Pro Forma	Pro Forma As Adjusted
	(dollars in thousands, except per share data)		
Cash and cash equivalents	$ 139,300	$ 123,910	
Long-term debt (including current maturities)	3,350	8,350	
Stockholders' equity:			
Common stock, $0.001 par value; 80,000,000 shares authorized; issued and outstanding: 20,000,000 shares—actual; 18,798,826 shares—pro forma; shares—pro forma, as adjusted	5	5	
Preferred stock, $0.001 par value; 20,000,000 shares authorized; no shares issued and outstanding, actual or as adjusted	—	—	
Retained earnings	95,262	74,872	
Total stockholders' equity	95,267	74,877	
Total capitalization	98,617	83,227	

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 as adjusted net tangible book value per share of common stock after giving effect to this offering.

Our net tangible book value as of December 31, 2002 was $89.2 million or $4.46 per share of common stock. Net tangible book value per share is determined by dividing net tangible book value, which is our tangible assets less total liabilities, by the number of shares of common stock outstanding. Our pro forma net tangible book value as of December 31, 2002 was $68.8 million or $3.66 per share of common stock, excluding the effect of the exercise of options to purchase shares of common stock that were vested as of December 31, 2002, and giving effect to the redemptions from certain of our stockholders of approximately $20.4 million of our common stock using cash reserves in January and February 2003 as if the redemptions occurred on December 31, 2002. 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 December 31, 2002 would have been $ million, or $ per share of common stock. This represents an immediate increase in the pro forma as adjusted net tangible book value of $ per share to our existing stockholders and an immediate dilution in the pro forma as adjusted 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 December 31, 2002	$	3.66
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 as adjusted basis to reflect the adjustments described above, as of December 31, 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 December 31, 2002, we had outstanding options to purchase 758,360 shares of common stock with a weighted average exercise price of $3.57 per share, of which 416,680 were vested. All previously unvested options will become fully vested upon the closing of this offering.

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SELECTED CONSOLIDATED FINANCIAL DATA

We derived the following selected consolidated financial data for the five years ended December 31, 2002 from our audited consolidated financial statements. You should read the data in conjunction with our consolidated financial statements, related notes, and other financial information included herein.

	Year Ended December 31,				
	1998	1999	2000(1)	2001(1)	2002(1)
	(dollars in thousands, except per share data)				
Statements of Income Data:					
Revenue:					
Premium revenue	$ 132,606	$ 181,929	$ 324,300	$ 499,471	$ 639,295
Other operating revenue	2,422	2,358	1,971	1,402	2,884
Investment income	863	1,473	3,161	2,982	1,982
Total operating revenue	135,891	185,760	329,432	503,855	644,161
Expenses:					
Medical care costs	116,149	148,138	264,408	408,410	530,018
Marketing, general and administrative expenses (including a charge for stock option settlements of $7,796 in 2002)	12,708	18,511	38,701	42,822	61,227
Depreciation and amortization	1,333	1,625	2,085	2,407	4,112
Total expenses	130,190	168,274	305,194	453,639	595,357
Operating income	5,701	17,486	24,238	50,216	48,804
Total other expense, net	(1,051)	(1,190)	(197)	(561)	(405)
Income before income taxes	4,650	16,296	24,041	49,655	48,399
Provision for income taxes	2,157	6,576	9,156	19,453	17,891
Income before minority interest	2,493	9,720	14,885	30,202	30,508
Minority interest	68	(267)	(79)	(73)	—
Net income	2,561	9,453	14,964	30,129	30,508
Basic net income per share					
Actual	0.13	0.47	0.75	1.51	1.53
Pro forma (2)	—	—	—	—	1.60
Diluted net income per share					
Actual	0.13	0.47	0.73	1.46	1.48
Pro forma (2)	—	—	—	—	1.55
Cash dividends declared per share	—	—	0.05	—	—
Weighted average number of common shares outstanding	20,000,000	20,000,000	20,000,000	20,000,000	20,000,000
Weighted average number of common shares and potential dilutive common shares outstanding (3)	20,000,000	20,173,000	20,376,000	20,572,000	20,609,000
Operating Statistics:					
Medical care ratio (4)	86.0%	80.4%	81.0%	81.5%	82.5%
Marketing, general and administrative expense ratio (5)	9.4%	10.0%	11.7%	8.5%	9.5%
Members (6)	162,000	199,000	298,000	405,000	489,000

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	As of December 31,						
	1998	1999(1)	2000(1)	2001(1)	2002(1)	2002 Pro Forma(2)	2002 Pro Forma As Adjusted(7)
	(dollars in thousands, except per share data)						
Balance Sheet Data:							
Cash and cash equivalents	$ 6,251	$ 26,120	$ 45,785	$ 102,750	$ 139,300	$ 123,910	$
Total assets	38,223	101,636	102,012	149,620	204,966	189,576	
Long-term debt (including current maturities)	57	17,296	3,448	3,401	3,350	8,350	
Total liabilities	27,028	80,991	67,405	84,861	109,699	114,699	
Stockholders’ equity	11,195	20,645	34,607	64,759	95,267	74,877	

(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 pro forma basic and diluted net income per share for the year ended December 31, 2002 and the pro forma balance sheet data as of December 31, 2002, give effect to the redemptions of 1,201,174 shares of common stock in January and February 2003 for cash payments of $20,390 and borrowing in March 2003 under the credit facility of $5,000. The pro forma basic and diluted net income per share reflect the redemptions and borrowing as occurring on January 1, 2002, and assume reduced investment income, increased interest expense, and reduced income taxes and net income. The pro forma balance sheet data reflect the redemptions and borrowing as occurring on December 31, 2002. See Note 12 to the Audited Consolidated Financial Statements.

(3) 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.

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

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

(6) Number of members at end of period.

(7) The pro forma as adjusted data give effect to the redemptions of shares of common stock and borrowing under the credit facility (see (2) above) and 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.

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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:

1980-1983	We opened three primary care clinics in Long Beach, California, providing health care to Medicaid beneficiaries.
1985	We obtained a contract 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.
1997-1999	We acquired a minority interest in the predecessor companies to our Michigan health plan in 1997. In 1999, we acquired a controlling interest in that plan.
1999	We acquired our Washington health plan, giving us an additional 60,000 members.
2002	Our enrollment reached 489,000 members at December 31, 2002.

We generate revenues primarily from premiums we receive from the states in which we operate. In 2002 we received approximately 94% 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 in the month members are entitled to receive health care services. We also received approximately 6% of our premium revenue from the Medicaid programs in Washington, Michigan and Utah for newborn deliveries, or birth income, on a per case basis which are recorded in the month the deliveries occur. Premium revenue is fixed in advance of the periods covered and is not subject to significant accounting estimates. Premium rates are periodically adjusted by the Medicaid programs.

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,		
	2000	2001	2002
California	184,000	229,000	253,000
Michigan	22,000	26,000	33,000
Utah	13,000	16,000	42,000
Washington	79,000	134,000	161,000
Total	298,000	405,000	489,000

Other operating revenue primarily includes fee-for-service revenue generated by our clinics in California and savings sharing revenues in California and Michigan where we receive additional incentive payments from the states if inpatient medical costs are less than prescribed amounts.

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. In general primary care physicians are paid on a capitation basis (a fixed amount per member per month regardless of actual utilization of medical services), while specialists and hospitals are paid on a fee-for-service basis. For the year ended December 31, 2002, approximately 74% 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 and case rates.

Capitation payments are fixed in advance of periods covered and are not subject to significant accounting estimates. These payments are expensed in the period the providers are obligated to provide services. Fee-for-service payments are expensed in the period services are provided to our members. Medical care costs include actual historical claims experience and estimates of medical expenses incurred but not reported, or IBNR. Monthly, we estimate our IBNR based on a number of factors, including prior claims experience, inpatient hospital utilization data and prior authorization of medical services. As part of this review, we also consider estimates of amounts to cover uncertainties related to fluctuations in provider billing patterns, claims payment patterns, membership and medical cost trends. These estimates are adjusted monthly as more information becomes available. We 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,		
	2000	2001	2002
Premium revenue	98.4%	99.1%	99.2%
Other operating revenue	0.6%	0.3%	0.5%
Investment income	1.0%	0.6%	0.3%
Total operating revenue	100.0%	100.0%	100.0%
Medical care ratio	81.0%	81.5%	82.5%
Marketing, general and administrative expenses	11.7%	8.5%	9.5%
Operating income	7.4%	10.0%	7.6%
Net income	4.5%	6.0%	4.7%

Year Ended December 31, 2002 Compared to Year Ended December 31, 2001

Premium Revenue

Premium revenue increased 28.0% or $139.8 million to $639.3 million in 2002 from $499.5 million in 2001, due to internal and acquisition-related membership growth, premium rate increases and changes in our Utah Medicaid contract. Approximately $115.7 million of the increase was due to membership growth, which increased 20.7% from 405,000 at December 31, 2001 to 489,000 at December 31, 2002. Of this increase, approximately 14,000 members were added through an acquisition by our Washington health plan effective July 1, 2002. Our health plans also received average annual rate increases of 3.2% which increased premium revenue by approximately $15.8 million in 2002. A revision in the Utah health plan contract effective July 1, 2002 resulted in approximately $8.3 million in additional revenues during the six month period ended December 31, 2002 as compared to 2001.

Other Operating Revenue

Other operating revenue increased 105.7% or $1.5 million to $2.9 million in 2002 from $1.4 million in 2001, primarily due to favorable settlements under savings sharing programs. During 2002, the Michigan and California HMOs received $1.2 million in savings sharing incentives for prior contract periods, which were in excess of amounts previously estimated.

Investment Income

Investment income primarily includes interest and dividend income. Investment income decreased 33.5% or $1.0 million to $2.0 million in 2002 from $3.0 million in 2001 due to lower investment yields, which was partially offset by an increase in the amount of funds invested.

Medical Care Costs

Medical care costs increased 29.8% or $121.6 million to $530.0 million in 2002 from $408.4 million in 2001. The medical care ratio for 2002 increased to 82.5% from 81.5% in 2001. The increase was attributed to higher inpatient costs in Michigan and specialty costs in California. Increased specialty costs primarily relate to emergency room visits and outpatient surgeries. The increased costs were partially offset by premium rate increases and additional revenues under the revised Utah Medicaid contract effective July 1, 2002.

Marketing, General and Administrative Expenses

MG&A expenses increased 43.0% or $18.4 million to $61.2 million in 2002 from $42.8 million in 2001. $9.5 million of the increase was due to increased personnel costs required to support our membership growth. Our employees, measured as full-time equivalents, increased from approximately 713 at December 31, 2001 to approximately 830 at December 31, 2002. Additionally during 2002, we agreed to acquire fully vested options to purchase 735,200 shares of our common stock from two executives for total cash payments of $8.7 million. The cash settlements resulted in a fourth quarter 2002 compensation charge of $7.8 million ($4.9 million net of tax effect). See Note 9 to the Consolidated Financial Statements. Premium taxes and regulatory fees also increased by $1.6 million in 2002 as compared to 2001 due to membership growth in the Washington health plan which pays premium taxes on revenue in lieu of state income taxes. Excluding the charge for stock option settlements, our MG&A expense ratio decreased to 8.3% for 2002, from 8.5% in 2001, due to higher total operating revenue in 2002.

Depreciation and Amortization

Depreciation and amortization expense increased 70.8% or $1.7 million to $4.1 million in 2002 from $2.4 million in 2001. During 2002, the Washington and California health plans recorded amortization expense related to intangible assets that were acquired through the assignment of Medicaid contracts in July 2002 and December 2001, respectively. These assets are amortized over the related contract terms (including renewal periods), not exceeding 18 months. Total amortization expense was $2.0 million in 2002 as compared to $0.4 million in 2001. Increased capital expenditures in computers and equipment accounted for the remaining increase.

Provision for Income Taxes

Income taxes totaled $17.9 million in 2002, resulting in an effective tax rate of 37.0%, as compared to $19.5 million in 2001, or an effective tax rate of 39.2%. The lower rate in 2002 was due to increased earnings generated from our Washington health plan which does not pay state income taxes and $0.4 million in additional California tax credits.

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

Premium Revenue

Premium revenue increased 54.0% or $175.2 million to $499.5 million in 2001 from $324.3 million in 2000. Approximately $152.8 million of the increase (including $18.6 million in additional birth income) 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 revenues due to the fact that average premiums are higher in Washington than in California at $137 and $89 per member per month, respectively, in 2001. The remaining increase was attributed to $7.9 million in additional revenue due to increased services offered by the Michigan health plan in 2001 and $14.5 million in premium rate increases, which averaged 4.5% during 2001.

Other Operating Revenue

Other operating revenue decreased 28.9% to $1.4 million in 2001 from $2.0 million in 2000, primarily due to lower fee-for-service revenue from our California clinics, which was partially offset by higher incentive payments under savings sharing programs in Michigan.

Investment Income

Investment income decreased 5.7% or $0.2 million to $3.0 million in 2001 from $3.2 million in 2000 due to lower investment yields, which was partially offset by an increase in the amounts of funds invested.

Medical Care Costs

Medical care costs increased 54.5% or $144.0 million to $408.4 million in 2001 from $264.4 million in 2000. The increase is largely attributable to growth in membership. The 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 increased 10.6% or $4.1 million to $42.8 million in 2001 from $38.7 million in 2000. As a percentage of total operating revenue, MG&A decreased from 11.7% to 8.5%. As a result of increased enrollment in each state, personnel costs increased $6.7 million and state premium taxes incurred by our Washington health plan increased $2.0 million. These increases were partially offset by a $4.0 million reduction in system support, consulting and outside service costs in 2001 due to contract changes and certain fiscal 2000 projects which did not recur in 2001, and $.6 million reduced expenses associated with our systems conversion, which we completed in 2000.

Depreciation and Amortization

Depreciation and amortization expense increased 15.4% to $2.4 million in 2002 from $2.1 million in 2000 due to increased expenditures for computers and equipment.

Provision for Income Taxes

Income taxes totaled $19.5 million in 2001, resulting in an effective tax rate of 39.2%, as compared to $9.2 million in 2000, or an effective tax rate of 38.1%. The lower tax rate in 2000 resulted from the reversal of a $645,000 non-deductible accrual for fines expected to be paid based on settlement discussions with the Office of Inspector General which asserted violations of marketing laws. See discussions under *Risks Related to Our Business*.

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 December 31, 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 year ended December 31, 2002 was approximately 1.7%.

Net cash provided by operations was $21.6 million in 2000, $61.4 million in 2001 and $45.7 million in 2002. 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. We had working capital of $20.3 million, $49.1 million and $74.6 million at December 31, 2000, 2001, and 2002, respectively.

At December 31, 2000, 2001 and 2002, cash and cash equivalents were $45.8 million, $102.8 million and $139.3 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 December 31, 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 2003. 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.

Credit Facility

We entered into a credit agreement dated as of March 19, 2003, under which the lenders provided a $75.0 million senior secured revolving credit facility. We plan to use this credit facility 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. On March 21, 2003, we borrowed $5.0 million under the credit facility.

Banc of America Securities LLC and CIBC World Markets Corp. are co-lead arrangers of the credit facility. Bank of America, N.A. is the administrative agent and CIBC World Markets Corp. is the syndication agent of the credit facility. Bank of America, N.A., U.S. Bank National Association, an affiliate of Banc of America Securities LLC, CIBC Inc. and Societe Generale, an affiliate of SG Cowen Securities Corporation, are lenders under the credit facility. The interest rate per annum is (a) LIBOR plus a margin ranging from 225 to 275 basis points or (b) the higher of (i) Bank of America prime or (ii) the federal funds rate plus 0.50%, plus a margin ranging from 125 to 175 basis points. If this offering raises net proceeds in excess of $50 million, the interest rate margin will be reduced to (A) 200 to 250 basis points for LIBOR rate loans or (B) 100 to 150 basis points for base rate loans. The credit facility will include a sublimit for the issuance of standby and commercial letters of credit to be issued by Bank of America, N.A. All amounts borrowed under the credit facility are due and payable in full by March 19, 2006. The credit facility is secured by certain real and personal property of the unregulated companies and, subject to certain limitations, all shares of certain subsidiaries. The credit facility requires us to perform within covenants and provides criteria for our acquisitions. We also are subject to customary terms and conditions and have incurred and will incur customary fees in connection with the credit facility. We intend to use the proceeds of this offering to repay amounts borrowed under the credit facility.

Redemptions

In January and February 2003, we redeemed 1,201,174 shares of our common stock at $16.98 per share from Janet M. Watt, Josephine M. Battiste, the Mary R. Molina Living Trust, the Mary Martha Molina Trust (1995), the Janet M. Watt Trust (1995) and the Josephine M. Molina Trust (1995). These stockholders held a combined interest of 40.0% prior to the redemption, which was reduced to 36.2%. The total cash payment of $20,390,000 was made from available cash reserves. The remainder beneficiaries of the Mary R. Molina Living Trust are J. Mario Molina, M.D., John C. Molina, J.D., M. Martha Bernadett, M.D., Janet M. Watt and Josephine M. Battiste. We agreed to the redemptions in response to requests for prompt liquidity by certain stockholders.

Employee Stock Ownership Plan

Prior to the closing of this offering, 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 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 loan to the ESOP trustee and the sale of shares by certain shareholders to the ESOP trustee are not yet finalized. The terms of the credit facility are described under *Credit Facility.*

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 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 risk based capital requirements for HMOs and has not formally given notice of its intention to do so. The National Association of Insurance Commissioners' HMO rules, if adopted by California, may increase the minimum capital required for that state.

As of December 31, 2002, our HMOs had aggregate statutory capital and surplus of approximately $53.0 million, compared with the required minimum aggregate statutory capital and surplus requirements of approximately $30.1 million. All our HMOs were in compliance with the minimum capital requirements.

Critical Accounting Policies

When we prepare our consolidated financial statements, we use estimates and assumptions that may affect reported amounts and disclosures. 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 actual historical claims experience and 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 adjusted for payment patterns, cost trends, product mix, seasonality, utilization of health care services and other relevant factors. The estimation methods and the resulting reserves are continually reviewed and updated, and adjustments, if necessary, are reflected in the period known. 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. As of December 31, 2002, our lease obligations for the next five years and thereafter are as follows: $4.5 million in 2003, $4.2 million in 2004, $3.9 million in 2005, $3.8 million in 2006, $2.6 million in 2007 and an aggregate of $13.9 million in 2008 and thereafter.

Our headquarters building in Long Beach, California is subject to a mortgage as of December 31, 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.

In May 2002, SFAS No. 145, *Rescission of FASB Statements No. 4, 44, and 64, Amendment of FASB Statement No. 13, and Technical Corrections as of April 2002* was issued. SFAS No. 145 is effective for fiscal years beginning after May 15, 2002. The adoption of the provisions of SFAS No. 145 is not expected to have a material impact on our financial position, results of operations or cash flows.

In June 2002, SFAS No. 146, *Accounting for Costs Associated with Exit or Disposal Activities*, which requires that a liability for a cost associated with an exit or disposal activity be recognized when the liability is incurred, was issued. SFAS No. 146 is effective for exit or disposal activities that are initiated after December 31, 2002. The adoption of the provisions of SFAS No. 146 is not expected to have a material impact on our financial position, results of operations or cash flows.

In December 2002, SFAS No. 148, *Accounting for Stock-Based Compensation—Transition and Disclosure*, was issued. SFAS No. 148 amends SFAS No. 123 *Accounting for Stock-Based Compensation* to provide alternative methods of transition to Statement 123’s fair value method of accounting for stock-based employee compensation. It also amends and expands the disclosure provisions of APB Opinion No. 28, *Interim Financial Reporting*, to require disclosure in the summary of significant accounting policies of the effects of an entity’s accounting policy with respect to stock-based employee compensation on reported net income and earnings per share in annual and interim financial statements. While SFAS No. 148 does not require companies to account for employee stock options using the fair-value method, the disclosure provisions apply to all companies regardless of whether they account for stock-based employee compensation using the fair value method of Statement 123 or the intrinsic value method of APB Opinion No. 25 *Accounting for Stock Issued to Employees*. We have adopted the disclosure provisions of SFAS No. 148.

Quantitative and Qualitative Disclosures About Market Risk

As of December 31, 2002, we had cash and cash equivalents of $139.3 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

The Health Insurance Portability and Accounting Act of 1996, the federal law designed to protect health information, contemplates establishment of physical and electronic security requirements for safeguarding health information. The U.S. Department of Health and Human Services recently finalized regulations establishing security requirements for health information. Such requirements may lead to additional costs related to the implementation of additional systems and programs 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 December 31, 2002, we had approximately 489,000 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 $644.2 million in 2002. Over the same period, our net income grew at a greater rate from $2.6 million to $30.5 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 estimates that the total health care expenditures for Medicaid and the State Children’s Health Insurance Program were $228.0 billion in 2001, $129.8 billion of which were federal funds, and $98.2 billion of which were state funds. The Centers for Medicare and Medicaid Services projects that total Medicaid and the State Children’s Health Insurance Program outlays will reach $372.9 billion in fiscal year 2007.

The State Children’s Health Insurance Program 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 the State Children’s Health Insurance Program through their Medicaid programs. The State Children’s Health Insurance Program enrollment reached 4.6 million in 2001, a 38% increase over 2000 enrollment figures. The Centers for Medicare and Medicaid Services data indicates that by fiscal year 2006 total the State Children’s Health Insurance Program outlays will be $4.3 billion.

The state and federal governments jointly finance Medicaid and the State Children’s Health Insurance Program 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 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 the Centers for Medicare and Medicaid Services, 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 Approach

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. Our approach to managed care is based on the following key attributes:

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 161,000 members as of December 31, 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 42,000 members as of December 31, 2002, an increase of 26,000 members during 2002. 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 diagnostics related groups. 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.

- *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 use 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 December 31, 2002

State	Total Members	LTM Operating Revenue (1)	Number of Contracts	Expiration Date
		(in thousands)		
California	253,000	$ 268,808	5	Varies between June 30, 2003 and December 31, 2004
Washington	161,000	$ 257,175	2	December 31, 2003
Michigan	33,000	$ 52,691	1	September 30, 2004
Utah	42,000	$ 63,505	2	June 30, 2004 and June 30, 2006

(1) Includes premium and other operating revenue for the twelve months ended December 31, 2002.

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 161,000 members at December 31, 2002. We serve members in 27 of the state's 39 counties. Effective July 1, 2002, we acquired approximately 14,000 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 1997. 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 stop loss guarantee 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.

The following table shows the total approximate number of primary care physicians, specialists and hospitals currently participating in our network as of December 31, 2002, 2001 and 2000:

		California	Washington	Michigan	Utah	Total
Primary care physicians	2002	2,414	1,860	495	794	5,563
	2001	2,156	1,794	413	730	5,093
	2000	2,017	1,753	339	607	4,716
Specialists	2002	9,266	6,446	1,055	1,986	18,753
	2001	9,697	5,527	965	1,741	17,930
	2000	9,129	5,125	1,091	1,380	16,725
Hospitals	2002	120	90	38	15	263
	2001	120	89	37	15	261
	2000	118	88	23	15	244

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

Primary Care Clinics. We operate 21 company-owned primary care clinics in California staffed by physicians, physician assistants, and nurse practitioners. In 2002, the clinics had over 143,000 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, diagnostic related groups and case rates.

Medical Management

Our experience in medical management extends back to our roots as a provider organization. We utilize primary care physicians 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 primary care physicians, 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 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. 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 the Centers for Medicare and Medicaid Services as of June 30, 2001, there were over 500 Medicaid managed care contractors nationwide, including multi-product managed care organizations, Medicaid-only HMOs, prepaid health plans and primary care case management programs. 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 managed care organization 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 the State Children's Health Insurance Program 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.

We expect to achieve compliance with HIPAA by the applicable deadlines. However, given its complexity, the recent adoption of some final regulations, the possibility that the regulations may change and may be subject to changing, and perhaps conflicting, interpretation, our ability to comply with all 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 32 facilities, including 21 medical clinics in California. We own a 32,000 square foot office building in Long Beach, California, which serves as our corporate headquarters.

Employees

As of December 31, 2002, we had approximately 830 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.

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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)	59	Director
Ronald Lossett, CPA, D.B.A. (1)(2)(3)	60	Director
Charles Z. Fedak, CPA (1)(2)(3)	51	Director
Carl D. Covitz (3)	63	Director

(1) Member of the Compensation Committee.
(2) Member of the Corporate Governance and Nominating Committee.
(3) Member of the Audit 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. From 1992-1994 she worked as a staff physician in family practice, from 1994-1996 she served as Associate Medical Director, from 1996-1999 she served as Vice President responsible for provider contracting and relations, network development, provider information, process improvement, credentialing and facility site review. Since 1999 she has served as Vice President and General Manager of the staff model operations of Molina Healthcare of California. Dr. Bernadett currently serves on the California Health Manpower Policy Commission and is the Principal Investigator on a grant from The Robert Wood Johnson Foundation to improve healthcare access for Latinos. 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.

Carl D. Covitz has served as a director since February 2003. Mr. Covitz is the owner and president of Landmark Capital, Inc., a national real estate development and investment company. From 1990 to 1993, he served as the Secretary of Business, Transportation and Housing of the State of California. From 1987 to 1989 Mr. Covitz served as Deputy Secretary of the U.S. Department of Housing and Urban Development. He is a

director of Arden Realty Inc., a publicly-traded real estate investment trust. Mr. Covitz is the past Chairman of the Board of the Federal Home Loan Bank of San Francisco. He earned an M.B.A. from the Columbia University Graduate School of Business.

Board of Directors

We have a seven member board of directors, four of whom are independent directors.

Board Committees

We have established an audit committee, a compensation committee and a corporate governance and 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 Charles Z. Fedak, Carl D. Covitz 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 corporate governance and nominating committee develops and oversees corporate governance processes and nominates candidates for election to the board of directors. The corporate governance and 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 $35,000. We also pay an additional annual retainer of $7,500 to the chair of the audit committee, $5,000 to each audit committee member and $2,500 to each of the chairs of the other committees. We pay each non-employee director $1,200 for each board and committee meeting attended in person; provided, however, audit committee members receive $2,400 for each audit committee meeting. Non-employee directors receive $600 for participation in telephonic meetings. Each non-employee director shall receive annually an option to purchase 4,000 shares of common stock, vested immediately, with an exercise price equal to fair market value at the time of grant. In addition, each non-employee director shall receive an option to purchase 10,000 shares of common stock, vesting over three years, with an exercise price equal to fair market value at the time of grant. We also pay certain expenses incurred by the directors.

We may, in our discretion, grant additional 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.

Executive Compensation

The following summary compensation table sets forth information concerning compensation earned in fiscal years 2002 and 2001 by individuals who served as our Chief Executive Officer and the remaining four most highly compensated executive officers as of December 31, 2002 and 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.	2002	$567,308	$500,000	$ 4,200	—	$ —	$ 7,430(5)
Chief Executive Officer, President, and Chairman	2001	400,000	250,000	7,200	—	—	7,100(5)
John C. Molina, J.D.	2002	453,846	278,592	4,200	—	—	7,013(6)
Executive Vice President, Financial Affairs, Treasurer and Director	2001	250,272	175,000	7,200	—	—	7,013(6)
George S. Goldstein, Ph.D.	2002	406,646	160,973	8,450	—	—	9,176(7)
Executive Vice President, Health Plan Operations and Director	2001	327,691	116,969	7,300	160,000	1,206,240	8,647(7)
Mark L. Andrews, Esq.	2002	362,169	129,336	4,550	—	—	7,277(8)
Executive Vice President, Legal Affairs, General Counsel and Corporate Secretary	2001	287,290	80,400	7,250	72,000	542,808	7,037(8)
Richard A. Helmer, M.D.	2002	284,677	66,723	7,500	—	—	7,373(9)
Vice President and Chief Medical Officer	2001	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 2002 and 2002 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 in 2002 and 2001 and insurance premiums of $630 and $300 in 2002 and 2001, respectively.
(6) 401(k) contributions of $6,800 in 2002 and 2001 and insurance premiums of $213 in 2001 and 2002.
(7) 401(k) contributions of $6,800 in 2002 and 2001 and insurance premiums of $2,376 and $1,847 in 2002 and 2001, respectively.
(8) 401(k) contributions of $6,800 in 2002 and 2001 and insurance premiums of $477 and $237 in 2002 and 2001, respectively.
(9) 401(k) contributions of $6,800 in 2002 and 2001 and insurance premiums of $573 and $694 in 2002 and 2001, respectively.

Option Grants In Last Fiscal Year. The following table sets forth information regarding stock options granted during the fiscal year ended December 31, 2002 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, 2002

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.	—	—	—	—	—	—	—
Mark L. Andrews, Esq.	—	—	—	—	—	—	—
Richard A. Helmer, M.D.	—	—	—	—	—	—	—

(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, 2002. Accordingly, the values of the unexercised in-the-money options have been calculated on the basis of the estimated fair market value at December 31, 2002 of $16.98 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 Fiscal Year Ended December 31, 2002
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.	—	—	80,000	80,000	998,000	998,000
Mark L. Andrews, Esq.	—	—	128,800	48,000	1,868,780	598,800
Richard A. Helmer, M.D.	—	—	—	57,120	—	712,572

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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 the January 1 after the effectiveness of the offering 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

Except for authorized grants of options to our non-employee directors to purchase an aggregate of 56,000 shares of common stock, we have frozen any further grants of stock based compensation under the 2000 Omnibus Stock and Incentive Plan. As of December 31, 2002, stock options to purchase a total of 758,360 shares at a weighted average exercise price of $3.57 per share were outstanding under the Plan.

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 the January 1 after the effectiveness of this offering 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 December 31, 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 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 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. The terms of the credit facility are described under *Credit Facility*.

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, executive officers and certain key 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

In 1996, we received 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) for the purchase of two medical buildings, which were subsequently leased to us (see Facility Leases below for discussion). The note receivable is secured by the two medical buildings and bears interest at 7% with monthly payments of $2,295 due through September 30, 2026. The balance outstanding at December 31, 2001 and 2002 was $321,000 and $316,000, respectively. The Molina Family Trust is not a beneficial owner of our common stock.

In 2001, we received a note receivable from the Molina Siblings Trust (of which John C. Molina, J.D. is the trustee and J. Mario Molina, M.D., John C. Molina, J.D., M. Martha Bernadett, M.D., Janet M. Watt and Josephine M. Battiste are the beneficiaries) for the purchase of a medical building, which was subsequently leased to us (see Facility Leases below for discussion). The note receivable was repaid in December 2002. The Molina Siblings Trust is a 17.9% beneficial owner of our common stock.

In 2000, we extended a $500,000 credit line to the Molina Siblings Trust. The balance outstanding, which bears interest at 7%, is due in 2010 and is secured by 86,189 shares of our common stock. The balance outstanding at December 31, 2001 and 2002 was $392,000 and $388,000, respectively.

Facility Leases

The agreement to lease the two medical buildings from the Molina Family Trust was entered into in April 1995. These leases have five 5-year renewal options and the rates may change every five years based on the

Consumer Price Index. Effective May 2001, we 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 and provides for fixed annual rate increases of 3% during the base term. Rental expense for these leases totaled $108,000, $295,000 and $390,000 for the years ended December 31, 2000, 2001 and 2002, respectively. Rental rates under these leases are equal to the average of the rates of our leases with third parties as a means of approximating fair value. Future minimum lease payments are as follows at December 31, 2002: $405,000 in 2003; $414,000 in 2004; $337,000 in 2005; $318,000 in 2006; $327,000 in 2007 and $82,000 thereafter.

Services Contracts

We received architecture services from a firm in which Janet M. Watt, sister of J. Mario Molina, M.D. and John C. Molina, J.D., was formerly a partner through 2001. Ms. Watt is a 1.1% beneficial owner of our common stock. We also received technology services from Laurence B. Watt, husband of Janet M. Watt. Aggregate payments for these services during the years ended December 31, 2000, 2001 and 2002 were $18,000, $130,000 and $86,000, respectively.

Split-Dollar Life Insurance

We are a party to Collateral Assignment Split-Dollar Insurance Agreements with the Molina Siblings Trust, the Trust. We agreed to make premium payments towards the life insurance policies held by the Trust on the life of Mary R. Molina, a former employee and director and a current stockholder, in exchange for services from Mrs. Molina when she served on our board of directors and was the director of our Child Health and Disability Prevention Department. The aggregate cash surrender value of the policies as of December 31, 2002 was $1,237,306. We are not an insured under the policies, but are entitled to receive repayment of all premium advances from the Trust upon the earlier of Mrs. Molina’s death or cancellation of the policies. Advances during December 31, 2000, 2001 and 2002 were $290,000, $786,000 and $653,000, respectively. Receivables at December 31, 2001 and 2002 were discounted based on Mrs. Molina’s remaining actuarial life using discount rates commensurate with instruments of similar terms and risk characteristics (6% and 4%, for 2001 and 2002, respectively). Such receivables totaled $878,000 and $1,496,000 at December 31, 2001 and 2002, respectively, and are secured by the cash surrender values of the policies.

Redemption of Stock

In January and February 2003, we redeemed 1,201,174 shares of our common stock at $16.98 per share from Janet M. Watt, Josephine M. Battiste, the Mary R. Molina Living Trust, the Mary Martha Molina Trust (1995), the Janet M. Watt Trust (1995) and the Josephine M. Molina Trust (1995). These stockholders held a combined interest of 40.0% prior to the redemption, which was reduced to 36.2%. The total cash payment of $20,390,000 was made from available cash reserves. The remainder beneficiaries of the Mary R. Molina Living Trust are J. Mario Molina, M.D., John C. Molina, J.D., M. Martha Bernadett, M.D., Janet M. Watt and Josephine M. Battiste. We agreed to the redemptions in response to requests for prompt liquidity by certain stockholders.

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PRINCIPAL STOCKHOLDERS

The following table sets forth information regarding the beneficial ownership of our common stock as of March 31, 2003 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 18,798,826 shares outstanding as of March 31, 2003, 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)	661,021	3.5%
John C. Molina, J.D. (3)	6,833,225	36.3%
William Dentino (4)	10,606,544	56.4%
Curtis Pedersen (5)	9,517,008	51.0%
Mary R. Molina Living Trust (6)	5,869,939	31.2%
Molina Marital Trust (7)	3,647,069	19.4%
Molina Siblings Trust (8)	3,356,000	17.9%
MRM GRAT 301/2 (9)	1,114,419	5.9%
MRM GRAT 301/3 (10)	1,057,427	5.6%
George S. Goldstein, Ph.D. (11)	160,000	*
Mark L. Andrews, Esq. (12)	176,800	*
Richard A. Helmer, M.D. (13)	57,120	*
Ronna Romney (14)	14,000	*
Ronald Lossett, CPA, D.B.A. (15)	14,000	*
Charles Z. Fedak, CPA (16)	14,000	*
Carl D. Covitz (17)	14,000	*
All executive officers and directors as a group (9 persons) (18)	8,551,691	44.6%

* 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 March 31, 2003.

(2) Includes 646,340 shares owned by J. Mario Molina, M.D.; 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.

(3) Includes 426,677 shares owned by John C. Molina; 11,881 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.D., M. Martha Bernadett, M.D., 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, our former director and the mother of J. Mario Molina, M.D., John C. Molina and M. Martha Bernadett, M.D., 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; 1,057,427 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; 323,058 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; 238,133 shares owned by the MRM GRAT 303/2, 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, M.D.'s children are the beneficiaries. Mr. Molina is a Director and our Executive Vice President, Financial Affairs, and Treasurer.

(4) Includes 5,869,939 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; 45,027 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; 237,303 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; 237,303 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 Mrs. Molina 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 5,869,939 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.

(6) Beneficial ownership is described in footnotes 4 and 5.

(7) Beneficial ownership is described in footnotes 4 and 5.

(8) Beneficial ownership is described in footnote 3.

(9) Beneficial ownership is described in footnote 3.

(10) Beneficial ownership is described in footnote 3.

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

(12) 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.

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

(14) Includes 14,000 shares which may be purchased pursuant to options. Ms. Romney is our director.

(15) Includes 14,000 shares which may be purchased pursuant to options. Mr. Lossett is our director.

(16) Includes 14,000 shares which may be purchased pursuant to options. Mr. Fedak is our director.

(17) Includes 14,000 shares which may be purchased pursuant to options. Mr. Covitz is our director.

(18) 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., Charles Z. Fedak, CPA, Carl D. Covitz.

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 December 31, 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

We are governed by the provisions of Section 203 of the Delaware General Corporation Law. In general, Section 203 prohibits a public Delaware corporation from engaging in a “business combination” with an “interested stockholder” for a period of three years after the date of the transaction in which the person became

an interested stockholder, unless the business combination is approved in a prescribed manner. A "business combination" includes mergers, asset sales or other transactions resulting in a financial benefit to the interested stockholder. An "interested stockholder" is a person who, together with affiliates and associates, owns (or within three years, did own) 15.0% or more of the corporation's outstanding voting stock. The statute could delay, defer or prevent a change of control of our company.

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 Continental Stock Transfer & Trust Company.

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 December 31, 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 758,360 shares are outstanding at December 31, 2002 under the frozen Omnibus Stock and Incentive Plan and prior grants. 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.

These activities may have the effect of raising or maintaining the market price of the common stock or preventing or retarding a decline in the market price of the common stock, and, as a result, 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.

Certain of the underwriters and their affiliates have provided, from time to time, and expect to provide in the future, investment and commercial banking and financial advisory services to us in the ordinary course of business, for which they have received and may continue to receive customary fees and commissions. CIBC World Markets Corp. is currently acting as advisor to us in connection with possible acquisition opportunities. Banc of America Securities LLC and CIBC World Markets Corp. are co-lead arrangers of the $75.0 million credit facility dated as of March 19, 2003. Bank of America, N.A. is the administrative agent and CIBC World Markets Corp. is the syndication agent of the credit facility. Bank of America, N.A., U.S. Bank National Association, an affiliate of Banc of America Securities LLC, CIBC Inc. and Societe Generale, an affiliate of SG Cowen Securities Corporation, are lenders under the credit facility.

Because affiliates of Banc of America Securities LLC, CIBC World Markets Corp. and SG Cowen Securities Corporation may, in aggregate, receive in excess of 10% of the proceeds in the offering in connection with our repayment of amounts outstanding under our credit facility, the offering is being conducted in accordance with Rule 2710(c)(8) and 2720 of the NASD Conduct Rules. These rules require that the initial public offering price may be no higher than that recommended by a “qualified independent underwriter,” as defined by the NASD. [   ] is serving in that capacity and has conducted due diligence and participated in the preparation of this prospectus and the registration statement of which this prospectus forms a part. The initial public offering price is not higher than the price recommended by [   ].

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, 2001 and 2002, 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.

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, 2001 and 2002, and the related consolidated statements of income, stockholders' equity and cash flows for each of the three years in the period ended December 31, 2002. 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 at December 31, 2001 and 2002, and the consolidated results of their operations and their cash flows for each of the three years in the period ended December 31, 2002, in conformity with accounting principles generally accepted in the United States.

Ernst & Young LLP

Los Angeles, California
January 31, 2003, except Notes 10 and 12, as to
which the dates are ________, 2003 and
March 21, 2003, respectively

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
January 31, 2003, except Note 12, as to
which the date is March 21, 2003

MOLINA HEALTHCARE, INC.

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

	December 31		Unaudited Pro Forma December 31, 2002
	2001	2002	
ASSETS			
Current assets:			
Cash and cash equivalents	$102,750	$139,300	$ 123,910
Receivables	21,078	29,591	29,591
Income taxes receivable	—	904	904
Deferred income taxes	1,561	2,083	2,083
Prepaid and other current assets	2,844	5,682	5,682
Total current assets	128,233	177,560	162,170
Property and equipment, net	9,637	13,660	13,660
Goodwill and intangible assets, net	4,768	6,051	6,051
Restricted investments	2,000	2,000	2,000
Deferred income taxes	1,477	2,287	2,289
Advances to related parties and other assets	3,505	3,408	3,408
Total assets	149,620	204,966	189,576
LIABILITIES AND STOCKHOLDERS' EQUITY			
Current liabilities:			
Medical claims and benefits payable	64,100	90,811	90,811
Accounts payable and accrued liabilities	10,903	12,074	12,074
Income taxes payable	4,087	—	—
Current maturities of note payable	51	55	55
Total current liabilities	79,141	102,940	102,940
Note payable, less current maturities	3,350	3,295	8,295
Other long-term liabilities	2,370	3,464	3,464
Total liabilities	84,861	109,699	114,699
Commitments and contingencies			
Stockholders' equity:			
Common stock, $0.001 par value; 80,000,000 shares authorized; issued and outstanding: 20,000,000 shares at December 31, 2001 and 2002, 18,798,826 pro forma shares at December 31, 2002, (see Note 12)	5	5	5
Preferred stock, $0.001 par value; 20,000,000 shares authorized, no shares issued and outstanding	—	—	—
Retained earnings	64,754	95,262	95,262
Less treasury stock (1,201,174 shares, at cost)	—	—	(20,390)
Total stockholders' equity	64,759	95,267	74,877
Total liabilities and stockholders' equity	149,620	204,966	189,576

See accompanying notes.

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MOLINA HEALTHCARE, INC.

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

	Year ended December 31		
	2000	2001	2002
Revenue:			
Premium revenue	$ 324,300	$ 499,471	$ 639,295
Other operating revenue	1,971	1,402	2,884
Investment income	3,161	2,982	1,982
Total operating revenue	329,432	503,855	644,161
Expenses:			
Medical care costs:			
Medical services	107,883	149,999	177,584
Hospital and specialty services	127,139	212,799	296,347
Pharmacy	29,386	45,612	56,087
Total medical care costs	264,408	408,410	530,018
Marketing, general and administrative expenses (including a charge for stock option settlements of $7,796 in 2002)	38,701	42,822	61,227
Depreciation and amortization	2,085	2,407	4,112
Total expenses	305,194	453,639	595,357
Operating income	24,238	50,216	48,804
Other income (expense):			
Interest expense	(578)	(347)	(438)
Other, net	381	(214)	33
Total other expense	(197)	(561)	(405)
Income before income taxes	24,041	49,655	48,399
Provision for income taxes	9,156	19,453	17,891
Income before minority interest	14,885	30,202	30,508
Minority interest	79	(73)	—
Net income	14,964	30,129	30,508
Unaudited pro forma net income (see Note 12)			30,155
Net income per share:			
Basic	0.75	1.51	1.53
Diluted	0.73	1.46	1.48
Unaudited pro forma net income per share (see Note 12):			
Basic			1.60
Diluted			1.55

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, 2000	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
Comprehensive income:					
Net income	—	—	—	30,508	30,508
Comprehensive income	—	—	—	30,508	30,508
Balance at December 31, 2002	20,000,000	5	—	95,262	95,267

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF CASH FLOWS
(dollars in thousands)

	Year ended December 31		
	2000	2001	2002
Operating activities			
Net income	$ 14,964	$ 30,129	$ 30,508
Minority interest	(79)	73	—
Adjustments to reconcile net income to net cash provided by operating activities:			
Depreciation and amortization	2,085	2,407	4,112
Deferred income taxes	(64)	(969)	(1,332)
Loss on disposal of property and equipment	245	416	38
Stock-based compensation	401	505	860
Changes in operating assets and liabilities:			
Receivables	(14,805)	11,610	(8,513)
Claims receivable—FHS Subsidiary	12,012	—	—
Prepaid and other current assets	7,529	(436)	(2,838)
Medical claims and benefits payable	389	14,585	26,711
Accounts payable and accrued liabilities	(2,345)	1,554	1,171
Income taxes payable (receivable)	1,269	1,478	(4,991)
Net cash provided by operating activities	21,601	61,352	45,726
Investing activities			
Proceeds from sale of marketable securities, net	1,938	—	—
Release of statutory deposits	—	1,050	—
Purchase of equipment	(1,758)	(2,105)	(6,206)
Other long-term liabilities	615	(486)	234
Advances to related parties and other assets	(695)	(1,537)	97
Net cash paid in purchase transactions	—	(1,250)	(3,250)
Net cash provided by (used in) investing activities	100	(4,328)	(9,125)
Financing activities			
Cash dividends declared	(1,000)	—	—
Maturity of restricted investments	12,800	—	—
Principal payments on notes payable and capital lease obligations	(13,836)	(59)	(51)
Net cash used in financing activities	(2,036)	(59)	(51)
Net increase in cash and cash equivalents	19,665	56,965	36,550
Cash and cash equivalents at beginning of year	26,120	45,785	102,750
Cash and cash equivalents at end of year	45,785	102,750	139,300
Supplemental cash flow information			
Cash paid during the period for:			
Income taxes	$ 7,950	$ 18,944	$ 24,215
Interest	580	342	352

See accompanying notes.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
(dollars in thousands, except per share data)
December 31, 2002

1. The Reporting Entity

Molina Healthcare, Inc. (the Company) is a multi-state managed care organization that arranges for the delivery of health care services to persons eligible for Medicaid and other programs for low-income families and individuals. The Company was founded in 1980 as a provider organization serving the Medicaid population through a network of primary care clinics in California. In 1994, the Company began operating as a health maintenance organization (HMO). 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 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 and other programs for low-income individuals, which represented at least 99% of the Company's premium revenue for each of the three years in the period ended December 31, 2002. Premium revenue includes per member per month fees received for providing substantially all contracted medical services and fee for service reimbursement for delivery of newborns on a per case basis (birth income). 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. Birth income is recorded during the month when services are rendered and accounted for 7% or less of total premium revenue during each of the three years in the period ended December 31, 2002.

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

due in part to premiums which the California HMO believed it was owed but had not been paid. Because of the uncertainty regarding collection of the disputed premiums from the subcontractor, the premiums were not recorded in years 1997 to 1999 for which they were due. In December 2000, the California HMO negotiated a $2,000 settlement. 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% of medical costs plus 9% of medical costs as an administrative fee. In addition, if the actual medical costs and administrative fee are less than a predetermined amount, 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. Under the stop loss agreement, the Utah HMO recognizes premium revenue equal to medical costs incurred, contracted administrative fee, and an estimate of the savings earned based on performance by its provider network, utilization management, and pharmacy benefit services.

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.

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. Under fee-for-service arrangements, the Company retains the financial responsibility for medical care provided at discounted payment rates. Expenses related to capitation and fee for service programs are recorded in the period in which the related services are dispensed.

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, changes in membership 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 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 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 in the period the services are dispensed, and are developed using actuarial methods based on historical claims recovery data.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

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

The following table shows the components of the change in medical claims and benefits payable for the years ended December 31, 2000, 2001 and 2002:

	Year ended December 31		
	2000	2001	2002
Balances as of January 1	$ 46,997	$ 49,515	$ 64,100
Components of medical care costs related to:			
Current year	268,699	412,052	534,349
Prior years	(4,291)	(3,642)	(4,331)
Total medical care costs	264,408	408,410	530,018
Payments for medical care costs related to:			
Current year	223,434	356,032	452,712
Prior years	38,456	37,793	50,595
Total paid	261,890	393,825	503,307
Balances as of December 31	49,515	64,100	90,811

The changes in medical care costs relating to prior years result from favorable settlement of claims and SSI recoveries as compared to previous estimates. These results are due to improvements in claims processing and utilization management, and successful SSI program cost recovery efforts in the state of Washington, which are favorable when compared to historical experience from which the original estimates were developed.

Provider Instability and Insolvency

The Company maintains insolvency reserves for estimated referral claims which are the responsibility of specifically identified capitated providers, where conditions indicate claims are not being paid or have slowed considerably. Depending on states’ laws, the Company may be held liable for unpaid health care claims that are the responsibility of the capitated provider and for which the provider has already received capitation. The Company continues to monitor the financial condition of providers where there is perceived risk of insolvency and adjusts such reserves as necessary. Information provided by providers may be unaudited, self-reported information or may not ultimately be obtained.

To reduce insolvency risk, the Company has developed contingency plans that include transferring members to other providers and reviewing operational and financial plans to monitor and maximize financial and network stability. As capitation contracts are renewed, management has also taken steps, where feasible, to establish security reserves for insolvency issues. Such reserves are frequently in the form of segregated funds from the provider that are held by the Company or in the provider’s name in a third-party financial institution. These funds may be used to pay claims that are the financial responsibility of the provider in the event the provider is unable to meet these obligations. At December 31, 2001 and 2002, the Company has recorded estimated losses arising from provider instability or insolvency, in excess of the security reserves.

Premium Deficiency Reserves on Loss Contracts

The Company assesses the profitability of its contracts for providing medical care services to its members when current operating results or forecasts indicate probable future losses. Anticipated future premiums are compared to medical care related costs, including estimated payments for physicians and hospitals, and the cost of processing claims. If the anticipated future costs exceed the premiums, a loss contract accrual is recognized. No such reserves were required as of December 31, 2001 and 2002.

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.

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, 2002, 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	
	2001	2002
California	$ 300	$ 300
Utah	550	550
Michigan	1,000	1,000
Washington	150	150
Total	2,000	2,000

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

Property and Equipment

Property and equipment are stated at historical cost. Replacements and major improvements are capitalized, and repairs and maintenance are charged to expense as incurred. Furniture, 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.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

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 SFAS No. 142, *Goodwill and Other Intangible Assets*. Accumulated amortization totaled $914 and $2,881 at December 31, 2001 and 2002, respectively. 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, 2000, 2001 and 2002:

	Year ended December 31		
	2000	2001	2002
Net income:			
As reported	$ 14,964	$ 30,129	$ 30,508
Adjusted	15,263	30,428	$ 30,508
Basic earnings per share:			
As reported	0.75	1.51	1.53
Adjusted	0.76	1.52	
Diluted earnings per share:			
As reported	0.73	1.46	1.48
Adjusted	0.75	1.48	

Long-Lived Asset Impairment

In August 2001, SFAS No. 144, *Accounting for the Impairment or Disposal of Long-Lived Assets* was issued. 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 adoption of SFAS No. 144 on January 1, 2002, had no effect on the Company's financial position, operating results or cash flows.

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 2002.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

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, $4,028 and $4,997 in 2000, 2001 and 2002, respectively, and are included in marketing, general and administrative expenses.

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

At December 31, 2002, the Company has one stock-based employee compensation plan, which is described more fully in Note 11. The Company accounts for the plan under the recognition and measurement principles (the intrinsic-value method) prescribed in Accounting Principles Board (APB) Opinion No. 25, *Accounting for Stock Issued to Employees*, and related interpretations. Compensation cost for stock options is reflected in net income and is measured as the excess of the market price of 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.

In December 2002, SFAS No. 148, *Accounting for Stock-Based Compensation—Transition and Disclosure* was issued. SFAS No. 148 amends SFAS No. 123 to provide alternative methods of transition to SFAS No. 123's fair value method of accounting for stock-based employee compensation. It also amends and expands the disclosure provisions of SFAS No. 123 and APB Opinion No. 28, *Interim Financial Reporting*, to require disclosure in the summary of significant accounting policies of the effects of an entity's accounting policy with respect to stock-based employee compensation on reported net income and earnings per share in annual and interim financial statements. While SFAS No. 148 does not require companies to account for employee stock options using the fair-value method, the disclosure provisions of SFAS No. 148 are applicable to all companies with stock-based employee compensation, regardless of whether they account for that compensation using the fair-value method of SFAS No. 123 or the intrinsic-value method of APB Opinion No. 25. The Company has adopted the disclosure requirements of SFAS No. 148.

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The following table illustrates the effect on net income and earnings per share if the Company had applied the fair value recognition provisions to stock-based employee compensation.

	Year ended December 31		
	2000	2001	2002
Net income, as reported	$ 14,964	$ 30,129	$ 30,508
Reconciling items (net of related tax effects):			
Add: Stock-based employee compensation expense determined under the intrinsic-value based method for all awards	248	307	542
Reduction in stock option settlements charge (see Note 9)	—	—	4,913
Deduct: Stock-based employee compensation expense determined under the fair-value based method for all awards	(410)	(519)	(620)
Net adjustment	(162)	(212)	4,835
Net income, as adjusted	14,802	29,917	35,343
Earnings per share:			
Basic—as reported	0.75	1.51	1.53
Basic—as adjusted	0.74	1.50	1.77
Diluted—as reported	0.73	1.46	1.48
Diluted—as adjusted	0.73	1.45	1.72

Earnings Per Share

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

	Year ended December 31		
	2000	2001	2002
Shares outstanding at the beginning of the period(1)	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
Dilutive effect of employee stock options(2)	376,000	572,000	609,000
Denominator for diluted earnings per share	20,376,000	20,572,000	20,609,000

(1) Adjusted to reflect 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.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

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 Affinity Fund and CADRE Reserve Fund (CADRE Funds), a portfolio of highly liquid money market securities. The CADRE Funds are a series of funds managed by the CADRE Institutional Investors Trust (Trust), a Delaware business trust registered as an open-end management investment. 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.

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 arranges for the provision of managed health care services 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 May 2002, SFAS No. 145, *Rescission of FASB Statements No. 4, 44, and 64, Amendment of FASB Statement No. 13, and Technical Corrections as of April 2002* was issued. As a result of the rescission of SFAS No. 4, gains and losses related to the extinguishment of debt should be classified as extraordinary only if they meet the criteria outlined under APB Opinion 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. 64, *Extinguishments of Debt Made to Satisfy Sinking-Fund Requirements*, was an

amendment to SFAS No. 4 and is no longer necessary. SFAS No. 44, *Accounting for Intangible Assets of Motor Carriers*, defined accounting requirements for the effects of the transition to the Motor Carrier Act of 1980. The transitions are complete and SFAS No. 44 is no longer necessary. SFAS No. 145 amends SFAS No. 13, *Accounting for Leases*, requiring that any capital lease that is modified resulting in an operating lease should be accounted for under the sale-leaseback provisions of SFAS No. 98, *Accounting for Leases* or SFAS No. 28, *Accounting for Sales with Leasebacks*, as applicable. SFAS No. 145 is effective for fiscal years beginning after May 15, 2002. The adoption of the provisions of SFAS No. 145 is not expected to have a material impact on the Company's results of operations, financial position or cash flows.

In June 2002, SFAS No. 146, *Accounting for Costs Associated with Exit or Disposal Activities*, which requires that a liability for a cost associated with an exit or disposal activity be recognized when the liability is incurred, was issued. This statement nullifies Emerging Issues Task Force Issue No. 94-3, *Liability Recognition for Certain Employee Termination Benefits and Other Costs to Exit an Activity (including Certain Costs Incurred in a Restructuring)*, which required that a liability for an exit cost be recognized upon the entity's commitment to an exit plan. SFAS No. 146 is effective for exit or disposal activities that are initiated after December 31, 2002. The adoption of the provisions of SFAS No. 146 is not expected to have a material impact on the Company's results of operations, financial position or cash flows.

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.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

On July 1, 2002, the Washington HMO paid $3,250 to another health plan for the assignment of a Medicaid contract. The assigned contract had a remaining term of six months on the acquisition date and was subsequently renewed for an additional one-year period as anticipated by the Company at the time of acquisition. 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	
	2001	2002
Land	$ 3,000	$ 3,000
Building and improvements	6,981	8,076
Furniture, equipment and automobiles	5,975	9,232
	15,956	20,308
Less accumulated depreciation and amortization	(6,319)	(6,648)
Property and equipment, net	9,637	13,660

5. Related Party Transactions

Advances to related parties are as follows:

	December 31	
	2001	2002
Note receivable due from Molina Family Trust, secured by two medical buildings, bearing interest at 7% with monthly payments due through 2026.	$ 321	$ 316
Note receivable due from Molina Siblings Trust, secured by a medical building, bearing interest at 7% with monthly payments due through 2016 (repaid in 2002).	1,093	—
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	878	1,496
	2,684	2,200

The Molina Family Trust has agreements with the Company to lease two medical clinics. These leases have five five-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 $108, $295 and $390 for the years ended December 31, 2000, 2001 and 2002, respectively. Minimum future lease payments consist of the following approximate amounts at December 31, 2002: $405 in 2003; $414 in 2004; $337 in 2005; $318 in 2006; $327 in 2007 and $82 thereafter.

The Company is a party to Collateral Assignment Split-Dollar Insurance Agreements (Agreements) with the Molina Siblings Trust (Trust). The Company agreed to make premium payments towards the life insurance policies held by the Trust on the life of Mary R. Molina, a former employee and director and a current shareholder, in exchange for services from Mrs. Molina. The Company is not an insured under the policies, but is entitled to receive repayment of all premium advances from the Trust upon the earlier of Mrs. Molina's death or cancellation of the policies. Advances through December 31, 2001 and 2002 of $1,723 and $2,376, respectively, were discounted based on the insured's remaining actuarial life, using discount rates commensurate with instruments of similar terms or risk characteristics (of 6% and 4%, for 2001 and 2002, respectively). Such receivables are secured by the cash surrender values of the policies.

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, 2000 and 2001 totaled $18 and $71, respectively. Payment for technology services received during the year ended December 31, 2001 totaled $59. No services were received during 2002.

6. Note Payable

During 1999, the Company obtained borrowings totaling $17,300 of which $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 rate 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 of which $12,800 was repaid using the proceeds of the matured restricted certificate of deposit. At December 31, 2001 and 2002, the outstanding mortgage note payable was $3,401 and $3,350, respectively.

Future payments on the mortgage note payable as of December 31, 2002, for the years ending December 31, are as follows:

2003	$	55
2004		60
2005		65
2006		71
2007		78
Thereafter		3,021
		3,350

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

7. Income Taxes

The provision for income taxes is as follows:

	Year ended December 31		
	2000	2001	2002
Current:			
Federal	$ 7,481	$ 17,541	$ 17,387
State	1,739	2,881	1,836
Total current	9,220	20,422	19,223
Deferred:			
Federal	21	(934)	(1,235)
State	(85)	(35)	(97)
Total deferred	(64)	(969)	(1,332)
	9,156	19,453	17,891

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

	Year ended December 31		
	2000	2001	2002
Taxes on income at statutory federal tax rate	$ 8,414	$ 17,379	$ 16,940
State income taxes, net of federal benefit	1,091	1,850	1,130
Nondeductible expenses	(226)	—	—
Nondeductible goodwill	104	104	—
Other	(227)	168	12
Change in valuation allowance	—	(48)	(191)
Reported income tax expense	9,156	19,453	17,891

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

	December 31	
	2001	2002
Accrued expenses	$ 368	$ 1,599
State taxes	975	747
Shared risk	75	(302)
Other, net	143	39
Deferred tax asset—current	1,561	2,083
Net operating losses	384	300
Depreciation and amortization	18	(221)
Deferred compensation	720	831
Other accrued medical costs	543	1,022
Other, net	3	355
	1,668	2,287
Valuation allowance	(191)	—
Deferred tax asset—long term	1,477	2,287
Net deferred income tax assets	3,038	4,370

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

At December 31, 2002, the Company had federal net operating loss carryforwards (NOLs) of approximately $934, which begin to expire in 2013. 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 in 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 $541, $737 and $1,007 in the years ended December 31, 2000, 2001 and 2002, respectively.

9. Commitments and Contingencies

Leases

The Company leases office space, clinics, equipment and automobiles, which expire at various dates through 2012. 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		
2003	$	4,479
2004		4,247
2005		3,924
2006		3,839
2007		2,555
Thereafter		13,946
		32,990

Rental expense related to these leases totaled $3,777, $4,239 and $4,930 for the years ended December 31, 2000, 2001 and 2002, respectively.

Legal

The health care industry is subject to numerous laws and regulations of federal, state and local governments. Compliance with these laws and regulations can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. 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

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

marketing activities for 60 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.

Employment Agreements

Terms

During 2001 and 2002, the Company entered into employment agreements with five executives with initial terms of one to three years, subject to automatic one-year extensions thereafter. The agreements provide for annual base salaries of $1,881 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 executives 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.

Certain employment agreements also provide for the executive's right to require the Company to repurchase all shares of common stock acquired by such executive pursuant to the exercise of stock options upon their termination 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 effectiveness of a public offering.

Stock Option Settlements

Under a previous employment agreement with one of the executives dated December 7, 1998, 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).

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

On November 7, 2002, the Company agreed to acquire fully vested stock options to purchase 640,000 shares of 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 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 transferable in the form of loans, advances or cash dividends without the consent of the regulators was $27.7 million and $30.1 million at December 31, 2001 and 2002, respectively.

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 (RBC) 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 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 December 31, 2002, our HMOs had aggregate statutory capital and surplus of approximately $53.0 million, compared with the required minimum aggregate statutory capital and surplus requirements of approximately $30.1 million. 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 (SEC) 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 Plans

The Company has made periodic grants of stock options to key employees under the 2000 Omnibus Stock and Incentive Plan (the 2000 Plan) and prior grants. Pursuant to the 2000 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 $2.00 to $4.50 per share, vest over 16 to 48 months and expire in 10 years. During the years ended December 31, 2000 and 2001, the Company issued options to purchase 181,760 and 378,000 shares of its common stock with an estimated total fair value of $313 and $2,850, respectively. No options were issued during the year ended December 31, 2002. Further grants under the 2000 Plan have been frozen.

The Company adopted the 2002 Equity Incentive Plan (2002 Plan) in 2002, which provides for the granting of stock options, restricted stock, performance shares and stock bonus awards to the Company's officers, employees, directors, consultants, advisors and other service providers. The 2002 Plan is effective upon the effectiveness of a public offering (the Effective Date). It currently allows for the issuance of 1,600,000 shares of common stock, of which up to 600,000 shares may be issued as restricted stock. Beginning the January 1 after the Effective Date, and each year thereafter, shares eligible for issuance will automatically increase by the lesser of 400,000 shares or 2% of total outstanding capital stock on a fully diluted basis, unless the board of directors provides for a smaller increase. Shares reserved for issuance under the 2000 Plan that are not needed for outstanding options granted will be included in the shares reserved for the 2002 Plan.

In July 2002, the Company adopted the 2002 Employee Stock Purchase Plan (Purchase Plan) which provides for the issuance of up to 600,000 common shares. The Purchase Plan is effective upon the effectiveness of a public offering (the Effective Date). Beginning the January 1 after the Effective Date and each year thereafter, shares eligible for issuance will automatically increase by the lesser of 6,000 shares or 1% of total outstanding capital stock on a fully diluted basis. During each six-month offering period beginning on the effective date of a public offering and each January 1 and July 1 thereafter, eligible employees may purchase common shares at 85% of their fair market value through payroll deductions, up to $25,000 per year.

No awards have been made under the 2002 Plan and the Purchase Plan.

At December 31, 2002, 632,840 of the Company's outstanding options were granted with exercise prices at below fair value. Compensation expense recognized in the consolidated statements of income in connection with these options was $401, $505 and $860 during 2000, 2001 and 2002, respectively.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

The Company estimates that amortization of deferred stock-based compensation, based upon stock options outstanding at December 31, 2002, and scheduled vesting periods, will consist of the following approximate amounts:

Year ending December 31	
2003	$ 585
2004	574
2005	103
	1,262

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.

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 6.13% and 5.54% in 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.

Stock option activity and related information is as follows:

	Year ended December 31					
	2000		2001		2002	
	Options	Weighted Average Exercise Price	Options	Weighted Average Exercise Price	Options	Weighted Average Exercise Price
Outstanding at beginning of period	990,040	$ 1.21	1,171,800	$ 1.61	1,498,600	$ 2.28
Granted	181,760	3.75	378,000	4.50	—	—
Exercised	—	—	—	—	—	—
Forfeited(a)	—	—	51,200	3.13	740,240	1.11
Outstanding at end of period	1,171,800	1.61	1,498,600	2.28	758,360	3.57
Exercisable at end of period	444,440	0.78	995,960	1.34	416,680	2.87
Weighted average per option fair value of options granted during the period		1.72		7.54		—

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

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

	Options Outstanding			Options Exercisable	
Range of Exercise Prices	Number Outstanding at December 31 2002	Weighted Average Remaining Contractual Life (Number of Months)	Weighted Average Exercise Price	Number of Exercisable at December 31 2002	Weighted Average Exercise Price
$2.00	254,840	82	$ 2.00	254,840	$ 2.00
3.13	47,760	88	3.13	31,840	3.13
4.50	455,760	105	4.50	130,000	4.50
2.00 – 4.50	758,360	96	3.57	416,680	2.87

12. Subsequent Event

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

The Company entered into a credit agreement dated as of March 19, 2003, under which the lenders provided a $75,000 credit facility and on March 21, 2003, the Company borrowed $5,000 under the facility. Interest is payable monthly at a rate per annum of (a) LIBOR plus a margin ranging from 225 to 275 basis points or (b) the higher of (i) Bank of America prime or (ii) the federal funds rate plus 0.50%, plus a margin ranging from 125 to 175 basis points. Pro forma interest expense assumes a weighted average interest rate of 4.25%. All borrowings under the credit facility are due and payable in full by March 19, 2006. The credit facility is secured by certain real and personal property of the unregulated companies and, subject to certain limitations, all shares of certain subsidiaries.

The accompanying unaudited pro forma consolidated balance sheet as of December 31, 2002 gives effect to the redemptions and borrowing as if they had occurred on December 31, 2002. The proforma net income and net income per share data appearing in the consolidated statement of income for the year ended December 31, 2002 give effect to the redemptions and borrowing as if they had occurred on January 1, 2002, and include the following adjustments:

	As Reported	Adjustment	Pro Forma
Investment income	$ 1,982	$ (347)	$ 1,635
Interest expense	(438)	(213)	(651)
Provision for income taxes	17,891	(207)	17,684
Net income	30,508	(353)	30,155
Basic net income per share	1.53	0.08	1.60
Dilutive net income per share	1.48	0.08	1.55
Weighted average number of common shares outstanding	20,000,000	(1,201,174)	18,798,826
Weighted average number of common shares and potential dilutive common shares outstanding	20,609,000	(1,201,174)	19,407,826

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13. Condensed Financial Information of Registrant

At December 31, 2002, the restricted net assets of the Company's subsidiaries exceed 25% of total consolidated net assets. Following are the condensed balance sheets of the Registrant as of December 31, 2001 and 2002, and the statements of income and cash flows for each of the three years in the period ended December 31, 2002.

Condensed Balance Sheets

	December 31	
	2001	2002
Assets		
Current assets:		
Cash and cash equivalents	$ 3,314	$ 27,597
Deferred income taxes	121	552
Due from affiliates	—	257
Prepaid and other current assets	917	1,862
Total current assets	4,352	30,268
Property and equipment, net	2,251	5,180
Investment in subsidiaries	64,115	65,557
Deferred income taxes	396	225
Advances to related parties and other assets	1,785	994
Total assets	72,899	102,224
Liabilities and stockholders' equity		
Current liabilities:		
Accounts payable and accrued liabilities	2,592	3,527
Income taxes payable	2,825	2,253
Due to affiliates	1,424	—
Total current liabilities	6,841	5,780
Other long-term liabilities	1,299	1,177
Total liabilities	8,140	6,957
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
Preferred stock, $0.001 par value; 20,000,000 shares authorized, no shares issued and outstanding	—	—
Retained earnings	64,754	95,262
Total stockholders' equity	64,759	95,267
Total liabilities and stockholders' equity	72,899	102,224

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

Condensed Statements of Income

	Year ended December 31,		
	2000	2001	2002
Revenue:			
Management fees	$ 16,650	$ 24,817	$ 42,553
Investment income	13	114	179
Total operating revenue	16,663	24,931	42,732
Expenses:			
Medical care costs	2,465	6,480	7,034
Marketing, general and administrative expenses (including a charge for stock option settlements of $7,796 in 2002)	11,484	15,926	29,834
Depreciation and amortization	102	636	1,095
Total expenses	14,051	23,042	37,963
Operating income	2,612	1,889	4,769
Other expense, net	(185)	(339)	(52)
Income before income taxes and equity in net income of subsidiaries	2,427	1,550	4,717
Provision for income taxes	902	697	2,001
Net income before equity in net income of subsidiaries	1,525	853	2,716
Equity in net income of subsidiaries	13,439	29,276	27,792
Net income	14,964	30,129	30,508

Condensed Statements of Cash Flows

	Year ended December 31		
	2000	2001	2002
Operating activities			
Cash (used in) provided by operating activities	$ 5,666	$ 984	$ 2,969
Investing activities			
Dividends from (capital contributions to) subsidiaries	(1,725)	2,200	26,350
Purchases of equipment	(1,226)	(1,763)	(4,024)
Changes in due to (from) affiliates	(903)	2,327	(1,584)
Change in other assets and liabilities	(234)	(1,062)	572
Net cash provided by (used in) investing activities	(4,088)	1,702	21,314
Financing activities			
Cash dividends declared	(1,000)	—	—
Net cash used in financing activities	(1,000)	—	—
Net increase in cash and cash equivalents	578	2,686	24,283
Cash and cash equivalents at beginning of year	50	628	3,314
Cash and cash equivalents at end of year	628	3,314	27,597

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. 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, credentialing, management, financial, legal, information systems and human resources services. Fees are based on the fair market value of services rendered and are recorded as operating revenue. Payment is subordinated to the subsidiaries' ability to comply with minimum capital and other restrictive financial requirements of the states in which they operate. Charges in 2000, 2001 and 2002 for these services totaled $16,650, $24,817 and $42,553, 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 2000, 2001 and 2002, the Registrant received dividends from its subsidiaries totaling $0, $5,900 and $31,000, respectively. Such amounts have been recorded as a reduction to the investments in the respective subsidiaries.

During 2000, 2001 and 2002, the Registrant made capital contributions to certain subsidiaries totaling $1,725, $3,700 and $4,650, 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.

[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

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.

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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 April , 2003.

MOLINA HEALTHCARE, INC.

By: ______________________________

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

Each person whose signature appears below hereby constitutes and appoints J. Mario Molina, M.D. and John C. Molina, J.D., and each of them, his true and lawful attorneys-in-fact and agents with full power or substitution and resubstitution, for him and in his name, place and stead, in any and all capacities, to sign any and all (1) amendments (including post-effective amendments) and additions to this registration statement, (2) registration statements, and any and all amendment thereto (including post-effective amendment), relating to the offering contemplated pursuant tot Rule 462(b) under the Securities Act of 1933, and file the same, with all exhibits thereto, and other documents in connection therewith, with the Securities and Exchange Commission, and hereby grants to such attorneys-in-fact and agents full power and authority to do and perform each and every act and thing requisite and necessary to be done, as fully to all intents and purposes as he or she might or could do in person, hereby ratifying and confirming all that said attorney-in-fact and agents or his substitute or substitutes may lawfully do or cause to be done by virtue hereof.

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
J. Mario Molina, M.D.	Chairman of the Board; Chief Executive Officer and President	April , 2003
John C. Molina, J.D.	Director; Executive Vice President, Financial Affairs, and Treasurer (Principal Financial Officer)	April , 2003
Harvey A. Fein	Vice President, Financial Affairs (Principal Accounting Officer)	April , 2003
George S. Goldstein, Ph.D.	Director; Executive Vice President, Health Plan Operations	April , 2003
Ronna Romney	Director	April , 2003
Ronald Lossett, CPA, D.B.A.	Director	April , 2003
Charles Z. Fedak, CPA	Director	April , 2003
Carl D. Covitz	Director	April , 2003

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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).

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.
10.15	Credit Agreement dated as of March 19, 2003.
21.1†	List of subsidiaries.
23.1	Consent of Ernst & Young LLP, Independent Auditors.
24.1	Powers of Attorney (contained in signature page).

* To be filed by amendment.

** Confidential treatment has been requested for portions of this Exhibit which have been filed separately with the Securities and Exchange Commission pursuant to Rule 406 promulgated under the Securities Act.

† Previously filed.

(b) *Financial Statement Schedules*

Molina Healthcare, Inc.

No.	Description
F-2	Report of Ernst & Young LLP, Independent Auditors
F-3	Consolidated Balance Sheets as of December 31, 2001 and 2002
F-4	Consolidated Statements of Income for the years ended December 31, 2000, 2001, and 2002
F-5	Consolidated Statements of Stockholders' Equity for the years ended December 31, 2000, 2001 and 2002
F-6	Consolidated Statements of Cash Flows for the years ended December 31, 2000, 2001 and 2002
F-7	Notes to Consolidated 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 April 11, 2003.

MOLINA HEALTHCARE, INC.

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

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

Each person whose signature appears below hereby constitutes and appoints J. Mario Molina, M.D. and John C. Molina, J.D., and each of them, his true and lawful attorneys-in-fact and agents with full power or substitution and resubstitution, for him and in his name, place and stead, in any and all capacities, to sign any and all (1) amendments (including post-effective amendments) and additions to this registration statement, (2) registration statements, and any and all amendment thereto (including post-effective amendment), relating to the offering contemplated pursuant tot Rule 462(b) under the Securities Act of 1933, and file the same, with all exhibits thereto, and other documents in connection therewith, with the Securities and Exchange Commission, and hereby grants to such attorneys-in-fact and agents full power and authority to do and perform each and every act and thing requisite and necessary to be done, as fully to all intents and purposes as he or she might or could do in person, hereby ratifying and confirming all that said attorney-in-fact and agents or his substitute or substitutes may lawfully do or cause to be done by virtue hereof.

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	April 11, 2003
/s/ JOHN C. MOLINA John C. Molina, J.D.	Director; Executive Vice President, Financial Affairs, and Treasurer (Principal Financial Officer)	April 11, 2003
/s/ HARVEY A. FEIN Harvey A. Fein	Vice President, Financial Affairs (Principal Accounting Officer)	April 11, 2003
/s/ GEORGE S. GOLDSTEIN George S. Goldstein, Ph.D.	Director; Executive Vice President, Health Plan Operations	April 11, 2003
/s/ RONNA ROMNEY Ronna Romney	Director	April 11, 2003
/s/ RONALD LOSSETT Ronald Lossett, CPA, D.B.A.	Director	April 11, 2003
/s/ CHARLES Z. FEDAK Charles Z. Fedak, CPA	Director	April 11, 2003
/s/ CARL D. COVITZ Carl D. Covitz	Director	April 11, 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 10.3

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: N/A		SHIPMENT: N/A
F.O.B.: N/A		SHIPPED FROM: 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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[GRAPHIC APPEARS HERE]

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[GRAPHIC APPEARS HERE]

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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- 100% of all anti-psychotics
- 100% of antiparkinson drugs, anticholinergic
- 60% 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.

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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:

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- 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.

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- 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.

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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.

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	HEALTH PLAN (COORDINATION AND COLLABORATION ROLES)	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.

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HEALTH PLAN MALPRACTICE LITIGATION REPORT

Report Date

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.

The Department of Community Health is an equal opportunity employer, services, and programs provider.

MSA-129 (9-99)

ANNUAL REPORT OF ENROLLMENT BY LINE OF BUSINESS AND COUNTY
MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

INSTRUCTIONS: Copy and attach this form if needed to list additional counties.

Name of Health Plan | Report Date | Report Year

ENROLLMENT INFORMATION:

COUNTY NAME	COMMERCIAL ENROLLMENT by LINE OF BUSINESS or CONTRACT TYPE						GOVERNMENT RELATED ENROLLMENT				
	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.

The Department of Community Health is an equal opportunity employer, services, and programs provider.

- ---

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

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

Report Date

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.

The Department of Community Health is an equal opportunity employer, services, and programs provider.

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

CONTRACT #071B1001026

[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	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 (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 (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) 241-1467 /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

HEALTH PLAN CONTRACT CHANGES TO BE EFFECTIVE OCTOBER 1, 2001

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 -------------------------

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;

(1) 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
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)241-1647 /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, Suite 303	Contact Person: Ed Ewia
	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

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State Purchasing: Date

ATTACHMENT "A"

UTAH DEPARTMENT OF HEALTH

GENERAL PROVISIONS

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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)

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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 $6.00 (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

PROVIDER NAME: ATTACHMENT E

SERVICE REPORTING PERIOD: TABLE 2 PAGE 2 OF 2

PAYMENT DATES: REVENUES AND COST

1	2	3	4	5	6	7	8	9
		MEDICAID (CAPITATED ONLY, NO FEE FOR SERVICE)						
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							

		10	11	12	13	14	15	16	17
		MEDICAID (CAPITATED ONLY, NO FEE FOR SERVICE)							
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!!

ATTACHMENT E
TABLE 3

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.

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:____
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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:____
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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:____
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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:____
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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:____
____
____

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:____
____
____

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:____
____
____

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

==

___ ____ TOTAL

Comments:____

____

____

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			
Federal Tax Identification Number or Social Security Number		State Purchasing	Date

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

		--------MEDICAID (CAPITATED ONLY, NO FEE FOR SERVICE)--------					
1	2	3	4	5	6	7	8
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						
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						
35	ACCRUED COSTS						
36	OTHER (SPECIFY)						
37	OTHER (SPECIFY)						
38	TOTAL MEDICAL COSTS	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0

* less than
** greater than

1	2	9	10	11	12	13	14	15	16	17
		--------------------MEDICAID (CAPITATED ONLY, NO FEE FOR SERVICE)---------------								
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

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: $2.00 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 $2.00 co-payment per date of service per provider. Annual calendar year maximum for any combination of physician, podiatry, outpatient hospital, and surgical centers is $100.00 per Enrollee.
Non-Traditional Medicaid: $3.00 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 $3.00 co-payment per date of service per provider. Counts toward total maximum co-payment and co-insurance of $500.00 per Enrollee per calendar year.

3. EMERGENCY DEPARTMENT SERVICES

Emergency Services provided to Enrollees in designated hospital emergency departments.

CO-PAYMENT
Traditional Medicaid: $6.00 co-payment for non-emergency use of the emergency room.
Non-Traditional Medicaid: $6.00 co-payment for non-emergency use of the emergency room. Counts toward total maximum co-payment and co-insurance of $500.00 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: $2.00 co-payment per visit. Limited to one co-payment per date of service per provider. Annual calendar year maximum is $100.00 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: $3.00 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 $500.00 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 $30.00. All amounts over $30.00 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: $3.00 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 $500.00 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: $2.00 co-payment per visit. Limited to one co-payment per date of service per provider. Annual calendar year maximum is $100.00 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: $3.00 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 $500.00 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: $2.00 co-payment per visit. Limited to one co-payment per date of service per provider. Annual calendar year maximum is $100.00 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: $3.00 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 $500.00 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 $220.00 co-insurance for non-emergency inpatient hospital admissions. The maximum co-payment per Enrollee per calendar year is $220.00 for non-emergency inpatient hospital admissions.

2. Emergency Department: Each enrollee must pay a $6.00 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 $2.00 co-payment per provider per day. The maximum co-payment per Enrollee per calendar year is $100.00 for any combination of the services provided by the above providers.

4. Prescription Drugs: Each Enrollee must pay a co-payment of $1.00 per prescription. The maximum co-payment is $5.00 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 $220.00 co-insurance for each non-emergency inpatient hospital admissions.

2. Emergency Department: Each enrollee must pay a $6.00 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 $3.00 co-payment per provider per day.

4. Prescription Drugs: Each Enrollee must pay a co-payment of $2.00 per prescription.*

The out-of-pocket maximum for each Enrollee is $500.00 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

SERVICE REPORTING PERIOD: BEGINNING ______ ENDING ______ MEDICAID ENROLLMENT

PAYMENT DATES: BEGINNING ______ ENDING ______

Effective Date: July 1, 2002

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
		TRADITIONAL MEDICAID RATE CELLS											NON-TRADITIONAL MEDICAID RATE CELLS				
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: --

SERVICE REPORTING PERIOD: BEGINNING --------- ENDING ----------

PAYMENT DATES: BEGINNING --------- ENDING ----------

ATTACHMENT E
TABLE 2 PAGE 1 OF 2
REVENUES AND COST

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

MEDICAID (CAPITATED ONLY, NO FEE FOR SERVICE)

TRADITIONAL MEDICAID RATE CELLS

1 LINE NO	2 DESCRIPTION	3 TOTAL UTAH OPERATIONS (INCLUDING ALL MEDICAID)	4 AGE 0-12 Mos.	5 TANF MALE 1-18	6 TANF FEMALE 1-18	7 AGED	8 DISABLED MALE	9 DISABLED FEMALE	10 MED NEEDY CHILD 1-18	11 NON TANF PREGNANT FEMALE	12 BREAST/ CERVICAL CANCER	13 RESTRICTION PROGRAM 0-18	14 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												

MEDICAID (CAPITATED ONLY, NO FEE FOR SERVICE)

NON-TRADITIONAL MEDICAID RATE CELLS

1 LINE NO	2 DESCRIPTION	15 TANF MALE 19 & OVER	16 TANF FEMALE 19 & OVER	17 MED NEEDY 19 & OVER	18 RESTRICTION PROGRAM 19 & OVER	19 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

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.

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)

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.

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).

EXHIBIT 10.15

EXECUTION COPY

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CREDIT AGREEMENT

Dated as of March 19, 2003

among

MOLINA HEALTHCARE, INC.,
a California corporation,

as the Borrower,

BANK OF AMERICA, N.A.,

as Administrative Agent

and

L/C Issuer,

CIBC WORLD MARKETS CORP.,

as Syndication Agent,

and

THE OTHER LENDERS PARTY HERETO

==================================

BANC OF AMERICA SECURITIES LLC,

and

CIBC WORLD MARKETS CORP.,
as
Co-Lead Arrangers

==================================

SOCIETE GENERALE,

as

Documentation Agent

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CREDIT AGREEMENT

This CREDIT AGREEMENT ("Agreement") is entered into as of March 19, 2003, among MOLINA HEALTHCARE, INC., a California corporation (the "Borrower"), each lender from time to time party hereto (collectively, the "Lenders" and individually, a "Lender"), BANK OF AMERICA, N.A., as Administrative Agent and L/C Issuer and CIBC WORLD MARKETS CORP., as Syndication Agent.

WITNESSETH:

WHEREAS, the Borrower has requested that the Lenders provide a revolving credit facility in the aggregate principal amount of $75 million, and the Lenders are willing to do so on the terms and conditions set forth herein;

NOW THEREFORE, in consideration of the mutual covenants and agreements herein contained, the parties hereto covenant and agree as follows:

ARTICLE I
DEFINITIONS AND ACCOUNTING TERMS

Section 1.01 Defined Terms. As used in this Agreement, the following terms shall have the meanings set forth below:

"Account Control Agreements" means, collectively, the Account Control Agreements each substantially in the form of Exhibits B-1 and B-2, as applicable, to the Security Agreement.

"Acquiring Party" has the meaning specified within the definition of Permitted Acquisitions.

"Acquisition", by any Person, means the purchase or acquisition by such Person of any capital stock of another Person other than a Loan Party or all or any substantial portion of the Property (other than the capital stock) of another Person other than a Loan Party, whether involving a merger or consolidation with such other Person.

"Administrative Agent" means Bank of America in its capacity as administrative agent and collateral agent, as applicable, under any of the Loan Documents, or any successor administrative agent.

"Administrative Agent's Office" means the Administrative Agent's address and, as appropriate, account as set forth on Schedule 10.02, or such other address or account as to which the Administrative Agent may from time to time notify the Borrower and the Lenders pursuant to Section 10.02 hereof.

"Administrative Services Agreements" means any and all administrative services, consulting, corporate allocation, management, tax allocation and similar agreements between or among the Borrower and any of its HMO Subsidiaries.

"Administrative Questionnaire" means an Administrative Questionnaire in a form supplied by the Administrative Agent.

"Affiliate" means, with respect to any Person, another Person that directly, or indirectly through one or more intermediaries, Controls or is Controlled by or is under common Control with the Person specified. "Control" means the power to direct or cause the direction of the management or policies of a Person, whether through the ability to exercise voting power, by contract or otherwise. "Controlling" and "Controlled" have meanings correlative thereto. Without limiting the generality of the foregoing, a Person shall be deemed to be Controlled by another Person if such other Person possesses, directly or indirectly, power to vote 10% or more of the securities having ordinary voting power for the election of directors, managing general partners or the equivalent.

"Agent-Related Persons" means the Administrative Agent, together with its Affiliates (including, in the case of Bank of America in its capacity as the Administrative Agent, Banc of America Securities in its capacity as a Co-Lead Arranger), and the officers, directors, employees, agents and attorneys-in-fact of such Persons and Affiliates.

"Aggregate Commitments" means the Commitments of all the Lenders.

"Agreement" means this Credit Agreement, as it may be amended, amended and restated, supplemented or otherwise modified from time to time.

"Applicable Rate" means the following percentages per annum, based upon the Consolidated Leverage Ratio as set forth in the most recent Compliance Certificate received by the Administrative Agent pursuant to Section 6.02(b):

APPLICABLE RATE
PRE-SUCCESSFUL IPO

PRICING LEVEL	CONSOLIDATED LEVERAGE RATIO	EURODOLLAR RATE + LETTERS OF CREDIT	BASE RATE +
1	* 1.5	2.75%	1.75%
2	* 1.0 but ** 1.5	2.5%	1.5%
3	** 1.0	2.25%	1.25%

* greater than
** less than

APPLICABLE RATE
POST-SUCCESSFUL IPO

PRICING LEVEL	CONSOLIDATED LEVERAGE RATIO	EURODOLLAR RATE + LETTERS OF CREDIT	BASE RATE +
1	* 1.5	2.5%	1.5%
2	* 1.0 but ** 1.5	2.25%	1.25%
3	** 1.0	2.0%	1.0%

Any increase or decrease in the Applicable Rate resulting from a change in the Consolidated Leverage Ratio shall become effective as of the first Business Day immediately following the date a Compliance Certificate is delivered pursuant to Section 6.02(b); provided, however, that if a Compliance Certificate is not delivered when due in accordance with such Section, then Pricing Level 1 shall apply for the period beginning on the first Business Day after the date on which such Compliance Certificate was required to have been delivered and continue until the date five Business Days after such Compliance Certificate is delivered, whereupon the Applicable Rate shall be adjusted based on the information contained in such Compliance Certificate. The Applicable Rate in effect from the Closing Date through and for a period of six months therefrom shall be determined based upon Pricing Level 1 of the Applicable Rate Pre-Successful IPO.

"Approved Fund" has the meaning specified in Section 10.07(g).

"Assignment and Assumption" means an Assignment and Assumption, substantially in the form of Exhibit D hereto.

"Attorney Costs" means and includes all reasonable fees, expenses and disbursements of any law firm or other external counsel.

"Attributable Indebtedness" means, on any date, in respect of any Capitalized Lease of any Person, the capitalized amount thereof that would appear on a balance sheet of such Person prepared as of such date in accordance with GAAP.

"Audited Financial Statements" means the audited consolidated balance sheets of the Borrower and the Subsidiaries for the fiscal years ended December 31, 2002, December 31, 2001 and December 31, 2000, and the related consolidated statements of income or operations, shareholders' equity and cash flows for each such fiscal years of the Borrower and the Subsidiaries, including the notes thereto.

"Availability Period" means the period from and including the Closing Date to the earliest of (a) the Maturity Date, (b) the date of termination of the Aggregate Commitments pursuant to Section 2.06, and (c) the date of termination of the Commitment of each Lender to

* greater than
** less than

make Loans and of the obligation of the of the L/C Issuer to make L/C Credit Extensions pursuant to Section 8.02.

"Banc of America Securities" means Banc of America Securities LLC and its successors.

"Bank of America" means Bank of America, N.A. and its successors.

"Base Rate" means, for any day a fluctuating rate per annum equal to the higher of (a) the Federal Funds Rate plus 1/2 of 1% and (b) the rate of interest in effect for such day as publicly announced from time to time by Bank of America as its "prime rate." The "prime rate" is a rate set by Bank of America based upon various factors including Bank of America's costs and desired return, general economic conditions and other factors, and is used as a reference point for pricing some loans, which may be priced at, above, or below such announced rate. Any change in such rate announced by Bank of America shall take effect at the opening of business on the day specified in the public announcement of such change.

"Base Rate Loan" means a Loan that bears interest based on the Base Rate.

"Borrower" has the meaning specified in the introductory paragraph hereto.

"Borrowing" means a borrowing consisting of simultaneous Loans of the same Type and, in the case of Eurodollar Rate Loans, having the same Interest Period made by each of the Lenders pursuant to Section 2.01.

"Building Finance Loan" means a loan to Molina Healthcare of California by California Federal Bank in a principal amount of $3.4 million used in 1999 to purchase the Borrower's corporate headquarters building located at One Golden Shore Drive, Long Beach, California 90802, which loan is secured by a Lien on such building.

"Businesses" has the meaning specified in Section 5.12(a).

"Business Day" means any day other than a Saturday, Sunday or other day on which commercial banks are authorized to close under the Laws of, or are in fact closed in, the state where the Administrative Agent's Office is located and, if such day relates to any Eurodollar Rate Loan, means any such day on which dealings in Dollar deposits are conducted by and between banks in the London interbank eurodollar market.

"Capital Assets" means, with respect to any Person, all equipment, fixed assets and real property or improvements, replacements or substitutions therefor or additions thereto, that, in accordance with GAAP, have been or should be reflected as additions to property, plant or equipment on the balance sheet of such Person or that have a useful life of more than one year.

"Capital Expenditures" means, for any period for any Person, without duplication (a) all expenditures made directly or indirectly during such period for Capital Assets (whether paid in cash or other consideration or accrued as a liability and including, without limitation, all expenditures for maintenance and repairs which are required, in accordance with GAAP, to be capitalized on the books of such Person) and (b) solely to the extent not otherwise included in clause (a) of this definition, the aggregate principal amount of all Indebtedness (including,

without limitation, obligations in respect of Capitalized Leases) assumed or incurred during such period in connection with any such expenditures for Capital Assets. For purposes of this definition, (i) Permitted Acquisitions shall not be included in Capital Expenditures, and (ii) the purchase price of equipment that is purchased simultaneously with the trade-in of existing assets, equipment or other property or with insurance proceeds, condemnation awards or other settlements in respect of lost, destroyed, damaged or condemned assets, equipment or other property shall be included in Capital Expenditures only to the extent of the gross amount by which such purchase price exceeds the credit granted by the seller of such asset, equipment or other property for the asset, equipment or other property being traded in at such time or the amount of such insurance proceeds, as the case may be.

"Capitalized Lease" means any lease with respect to which the lessee is required to recognize concurrently the acquisition of property or an asset and the incurrence of a liability in accordance with GAAP.

"Cash Collateralize" has the meaning specified in Section 2.03(g).

"CHAMPUS" means the United States Department of Defense Civilian Health and Medical Program of the Uniformed Services.

"Change of Control" means, with respect to any Person, an event or series of events by which:

(a) any "person" or "group" (as such terms are used in Sections 13(d) and 14(d) of the Securities Exchange Act of 1934, but excluding any employee benefit plan of such person or its subsidiaries and any person or entity acting in its capacity as trustee, agent or other fiduciary or administrator of any such plan) becomes the "beneficial owner" (as defined in Rules 13d-3 and 13d-5 promulgated under the Securities Exchange Act of 1934, except that a person or group shall be deemed to have "beneficial ownership" of all securities that such person or group has the right to acquire (such right, an "option right"), whether such right is exercisable immediately or only after the passage of time), directly or indirectly, of 30% or more of the equity securities of such Person entitled to vote for members of the board of directors or equivalent governing body of such Person on a fully-diluted basis (and taking into account all such securities that such person or group has the right to acquire pursuant to any option right); or

(b) during any period of 12 consecutive months, a majority of the members of the board of directors or other equivalent governing body of such Person cease to be composed of individuals (i) who were members of that board or equivalent governing body on the first day of such period, (ii) whose election or nomination to that board or equivalent governing body was approved by individuals referred to in clause (i) above constituting at the time of such election or nomination at least a majority of that board or equivalent governing body or (iii) whose election or nomination to that board or other equivalent governing body was approved by individuals referred to in clauses (i) and (ii) above constituting at the time of such election or nomination at least a majority of that board or equivalent governing body (excluding, in the case of both clause (ii) and clause (iii), any individual whose initial nomination for, or assumption of office as, a member of

that board or equivalent governing body occurs as a result of an actual or threatened solicitation of proxies or consents for the election or removal of one or more directors by any person or group other than a solicitation for the election of one or more directors by or on behalf of the board of directors); or

(c) any Person or two or more Persons acting in concert shall have acquired by contract or otherwise, or shall have entered into a contract or arrangement that, upon the consummation thereof, will result in its or their acquisition of power to exercise, directly or indirectly, a controlling influence over the management or policies of the Borrower or control over the equity Securities of the Borrower entitled to vote for members of the board of directors or equivalent governing body of the Borrower on a fully diluted basis (and taking into account all such securities that such Person or group has the right to acquire pursuant to any option right) representing 30% or more of the combined voting power of such securities; provided, however, that notwithstanding any of the foregoing, transfers of equity securities among members of the Molina Family and/or trusts beneficially owned by any member of the Molina Family shall not be considered a Change of Control hereunder.

"Closing Date" means the first date all the conditions precedent in Section 4.01 are satisfied or waived in accordance with Section 4.01 (or, in the case of Section 4.01(d), waived by the Person entitled to receive the applicable payment).

"CIBC Inc." means CIBC Inc. and its successors.

"CMS" means the Centers for Medicare and Medicaid Services and any successor thereof.

"Code" means the Internal Revenue Code of 1986.

"Co-Lead Arrangers" means Banc of America Securities, in its capacity as a co-lead arranger, and CIBC World Markets Corp., in its capacity as a co-lead arranger.

"Collateral" means all the "Collateral" referred to in the Collateral Documents.

"Collateral Documents" means, collectively, the Security Agreement, the Pledge Agreement, each Account Control Agreement, each Waiver Agreement, each Mortgage and any other security agreements, pledge agreements or similar instruments delivered to the Administrative Agent as collateral agent from time to time pursuant to Sections 6.13, 6.14 and 6.15 and each other agreement, instrument or document that creates or purports to create a Lien in favor of the Administrative Agent, as collateral agent, for the benefit of the Secured Parties.

"Commitment" means, as to each Lender, its obligation to (a) make Loans to the Borrower pursuant to Section 2.01, and (b) purchase participations in L/C Obligations, in an aggregate principal amount at any one time outstanding not to exceed the amount set forth opposite such Lender's name on Schedule 2.01 or in the Assignment and Assumption pursuant to which such Lender becomes a party hereto, as applicable, as such amount may be adjusted from time to time in accordance with this Agreement.

"Commitment Letter" means the commitment letter agreement, dated February 1, 2003 among the Borrower, Bank of America, CIBC Inc. and the Co-Lead Arrangers.

"Company Action Level" means the Company Action Level risk-based capital threshold, as defined by the HMO Model Act.

"Compensation Period" has the meaning specified in Section 2.12(c)(ii).

"Compliance Certificate" means a certificate substantially in the form of Exhibit C hereto.

"Consolidated EBITDA" means, for any period for the Borrower and the Subsidiaries on a consolidated basis in accordance with GAAP, an amount equal to Consolidated Net Income for such period, plus the following to the extent deducted in calculating such Consolidated Net Income: (i) Consolidated Interest Charges for such period; (ii) the provision for federal, state, local and foreign income taxes for such period; and (iii) the amount of depreciation and amortization expense deducted in determining such Consolidated Net Income.

"Consolidated Funded Indebtedness" means, for the Borrower and the Subsidiaries determined on a consolidated basis in accordance with GAAP, as of any date of determination, the sum of (a) the outstanding principal amount of all obligations, whether current or long-term, for borrowed money (including Obligations hereunder) and all obligations evidenced by bonds, debentures, notes, loan agreements or other similar instruments, (b) all purchase money Indebtedness, (c) all direct obligations arising under letters of credit (including standby and commercial), bankers' acceptances, bank guaranties, surety bonds and similar instruments, (d) all obligations in respect of the deferred purchase price of property or services (other than trade accounts payable in the ordinary course of business), (e) Attributable Indebtedness in respect of Capitalized Leases, (f) the attributed principal amount of Securitization Transactions, (g) all preferred stock or comparable equity interests providing for mandatory redemption, sinking fund or other like payments, (h) without duplication, all Guarantees with respect to outstanding Indebtedness of the types specified in clauses (a) through (g) above, and (i) all Indebtedness of the types referred to in clauses (a) through (h) above of any partnership or joint venture (other than a joint venture that is itself a corporation or limited liability company) in which such Person is a general partner or joint venturer, unless such Indebtedness is expressly made non-recourse to such Person.

"Consolidated Interest Charges" means, for any period, for the Borrower and the Subsidiaries on a consolidated basis, all consolidated interest expense in accordance with GAAP with respect to Indebtedness for borrowed money (including capitalized interest) or in connection with the deferred purchase price of assets.

"Consolidated Leverage Ratio" means, as of any date of determination, the ratio of (a) Consolidated Funded Indebtedness as of such date to (b) Consolidated EBITDA for the period of the four fiscal quarters most recently ended for which the Borrower has delivered financial statements pursuant to Section 6.01(a) or (b).

"Consolidated Net Income" means, for any period, on a consolidated basis, the Net Income of the Borrower and the Subsidiaries on a consolidated basis for that period.

"Consolidated Net Worth" means, as of any date of determination, for the Borrower and the Subsidiaries on a consolidated basis, Shareholders' Equity of the Borrower and the Subsidiaries on a consolidated basis on that date as determined in accordance with GAAP.

"Contract Provider" means any Person or any employee, agent or subcontractor of such Person who provides professional health care services under or pursuant to any contract with the Borrower or any of the Subsidiaries.

"Contractual Obligation" means, as to any Person, any provision of any security issued by such Person or of any agreement, instrument or other undertaking to which such Person is a party or by which it or any of its property is bound.

"Control" has the meaning specified in the definition of "Affiliate."

"Credit Extension" means each of the following: (a) a Borrowing; and (b) an L/C Credit Extension.

"Debtor Relief Laws" means the Bankruptcy Code of the United States, and all other liquidation, conservatorship, bankruptcy, assignment for the benefit of creditors, moratorium, rearrangement, receivership, insolvency, reorganization, or similar debtor relief Laws of the United States or other applicable jurisdictions from time to time in effect and affecting the rights of creditors generally.

"Default" means any event or condition that constitutes an Event of Default or that, with the giving of any notice, the passage of time, or both, would be an Event of Default.

"Default Rate" means an interest rate equal to (a) in the case of Eurodollar Rate Loans, the sum of (i) the Eurodollar Rate for such Loans, plus (ii) the Applicable Rate applicable to such Loans, plus (iii) 2% per annum, and (b) in the case of Base Rate Loans and for all other purposes, the sum of (i) the Base Rate plus (ii) the Applicable Rate, if any, applicable to Base Rate Loans plus (iii) 2% per annum.

"Defaulting Lender" means any Lender that (a) has failed to fund any portion of the Loans or participations in L/C Obligations required to be funded by it hereunder within one Business Day of the date required to be funded by it hereunder, (b) has otherwise failed to pay over to the Administrative Agent or any other Lender any other amount required to be paid by it hereunder within one Business Day of the date when due, unless the subject of a good faith dispute, or (c) has been deemed insolvent or become the subject of a bankruptcy or insolvency proceeding.

"Disposition" or "Dispose" means the sale, transfer, license, lease or other disposition (including any sale and leaseback transaction) of any property by any Person, including any sale, assignment, transfer or other disposal, with or without recourse, of any notes or accounts receivable or any rights and claims associated therewith.

"Dollar" and "$" mean lawful money of the United States.

"EBITDA" means, for any period for any Person, an amount equal to Net Income for such period, plus the following to the extent deducted in calculating such Net Income: (i) Interest Charges for such period; (ii) the provision for federal, state, local and foreign income taxes payable for such period; and (iii) the amount of depreciation and amortization expense deducted in determining such Net Income.

"EBITDAR" means for any period for any Person, EBITDA for such period plus Rental Expense.

"Eligible Assignee" has the meaning specified in Section 10.07(g).

"Eligible Subsidiary" means any Subsidiary, other than a Subsidiary that is restricted by HMO Regulations from giving a guaranty of the Loans and other Obligations under this Agreement pursuant to a Subsidiary Guaranty.

"Environmental Laws" means any and all Federal, state, local, and foreign statutes, laws, regulations, ordinances, rules, judgments, orders, decrees, permits, concessions, grants, franchises, licenses, agreements or governmental restrictions relating to pollution and the protection of the environment or the release of any materials into the environment, including those related to hazardous substances or wastes, air emissions and discharges to waste or public systems.

"Environmental Liability" means any liability, contingent or otherwise (including any liability for damages, costs of environmental remediation, fines, penalties or indemnities), of the Borrower, any other Loan Party or any of their respective Subsidiaries directly or indirectly resulting from or based upon (a) violation of any Environmental Law, (b) the generation, use, handling, transportation, storage, treatment or disposal of any Hazardous Materials, (c) exposure to any Hazardous Materials, (d) the release or threatened release of any Hazardous Materials into the environment or (e) any contract, agreement or other consensual arrangement pursuant to which liability is assumed or imposed with respect to any of the foregoing.

"ERISA" means the Employee Retirement Income Security Act of 1974.

"ERISA Affiliate" means any trade or business (whether or not incorporated) under common control with the Borrower within the meaning of Section 414(b) or (c) of the Code (and Sections 414(m) and (o) of the Code for purposes of provisions relating to Section 412 of the Code).

"ERISA Event" means (a) a Reportable Event with respect to a Pension Plan; (b) a withdrawal by the Borrower or any ERISA Affiliate from a Pension Plan subject to Section 4063 of ERISA during a plan year in which it was a substantial employer (as defined in Section 4001(a)(2) of ERISA) or a cessation of operations that is treated as such a withdrawal under Section 4062(e) of ERISA; (c) a complete or partial withdrawal by the Borrower or any ERISA Affiliate from a Multiemployer Plan or notification that a Multiemployer Plan is in reorganization; (d) the filing of a notice of intent to terminate, the treatment of a Plan amendment

as a termination under Sections 4041 or 4041A of ERISA, or the commencement of proceedings by the PBGC to terminate a Pension Plan or Multiemployer Plan; (e) an event or condition which constitutes grounds under Section 4042 of ERISA for the termination of, or the appointment of a trustee to administer, any Pension Plan or Multiemployer Plan; or (f) the imposition of any liability under Title IV of ERISA, other than for PBGC premiums due but not delinquent under Section 4007 of ERISA, upon the Borrower or any ERISA Affiliate.

"Eurodollar Rate" means for any Interest Period with respect to any Eurodollar Rate Loan:

(a) the rate per annum equal to the rate determined by the Administrative Agent to be the offered rate that appears on the page of the Telerate screen (or any successor thereto) that displays an average British Bankers Association Interest Settlement Rate for deposits in Dollars (for delivery on the first day of such Interest Period) with a term equivalent to such Interest Period, determined as of approximately 11:00 a.m. (London time) two Business Days prior to the first day of such Interest Period; or

(b) if the rate referenced in the preceding subsection (a) does not appear on such page or service or such page or service shall not be available, the rate per annum equal to the rate determined by the Administrative Agent to be the offered rate on such other page or other service that displays an average British Bankers Association Interest Settlement Rate for deposits in Dollars (for delivery on the first day of such Interest Period) with a term equivalent to such Interest Period, determined as of approximately 11:00 a.m. (London time) two Business Days prior to the first day of such Interest Period; or

(c) if the rates referenced in the preceding subsections (a) and (b) are not available, the rate per annum determined by the Administrative Agent as the rate of interest at which deposits in Dollars for delivery on the first day of such Interest Period in same day funds in the approximate amount of the Eurodollar Rate Loan being made, continued or converted by Bank of America and with a term equivalent to such Interest Period would be offered by Bank of America's London branch to major banks in the London interbank eurodollar market at their request at approximately 4:00 p.m. (London time) two Business Days prior to the first day of such Interest Period.

"Eurodollar Rate Loan" means a Loan that bears interest at a rate based on the Eurodollar Rate.

"Event of Default" has the meaning specified in Section 8.01.

"Exclusion Event" means the exclusion of the Borrower or any of the Subsidiaries from participation in any Medical Reimbursement Program.

"Federal Funds Rate" means, for any day, the rate per annum equal to the weighted average of the rates on overnight Federal funds transactions with members of the Federal Reserve System arranged by Federal funds brokers on such day, as published by the Federal

Reserve Bank on the Business Day next succeeding such day; provided that (a) if such day is not a Business Day, the Federal Funds Rate for such day shall be such rate on such transactions on the next preceding Business Day as so published on the next succeeding Business Day, and (b) if no such rate is so published on such next succeeding Business Day, the Federal Funds Rate for such day shall be the average rate (rounded upward, if necessary, to a whole multiple of 1/100 of 1%) charged to Bank of America on such day on such transactions as determined by the Administrative Agent.

"Fee Letter" means the fee letter agreement, dated February 1, 2003 among the Borrower, Bank of America, CIBC Inc. and the Co-Lead Arrangers.

"Fixed Charge Coverage Ratio" means, for any period, the ratio of (i) the sum of the Borrower's unconsolidated EBITDAR, plus EBITDAR of any other Loan Party, plus Net Dividends, to (ii) the sum of Fixed Charges of the Borrower and any other Loan Party, plus Capital Expenditures of the Borrower and any other Loan Party.

"Fixed Charges" means, for any period for any Person, the sum of (i) the aggregate amount of taxes paid in cash, plus (ii) interest payable on all Indebtedness for borrowed money, plus (iii) rent payable under leases of real, personal, or mixed property, plus (iv) scheduled principal payments on all Indebtedness for borrowed money.

"Foreign Lender" has the meaning specified in Section 10.15(a)(i).

"Foreign Subsidiary" means a subsidiary that is not organized under the Laws of a political subdivision of the United States.

"FRB" means the Board of Governors of the Federal Reserve System of the United States.

"Fund" has the meaning set forth in Section 10.07(g).

"GAAP" means generally accepted accounting principles in the United States set forth in the opinions and pronouncements of the Accounting Principles Board and the American Institute of Certified Public Accountants and statements and pronouncements of the Financial Accounting Standards Board, that are applicable to the circumstances as of the date of determination, consistently applied.

"Governmental Authority" means any nation or government, any state or other political subdivision thereof, any agency, authority, instrumentality, regulatory body, court, administrative tribunal, central bank or other entity exercising executive, legislative, judicial, taxing, regulatory or administrative powers or functions of or pertaining to government.

"Governmental Reimbursement Program Cost" means with respect to and payable by the Borrower and the Subsidiaries, the sum of:

(a) all amounts (including punitive and other similar amounts) agreed to be paid or payable (i) in settlement of claims made pursuant to any litigation, suit, arbitration, investigation or other legal or administrative proceeding relating to a dispute

or (ii) as a result of a final, non-appealable judgment, award or similar order, in each case, relating to participation in Medical Reimbursement Programs;

(b) all final, non-appealable fines, penalties, forfeitures or other amounts rendered pursuant to criminal indictments or other criminal proceedings relating to participation in Medical Reimbursement Programs; and

(c) the amount of final, non-appealable recovery, damages, awards, penalties, forfeitures or similar amounts rendered in any litigation, suit, arbitration, investigation or other legal or administrative proceeding of any kind relating to participation in Medical Reimbursement Programs.

"Guarantor" means each Eligible Subsidiary identified as a "Guarantor" on the signature pages to the Subsidiary Guaranty and each other Person that joins as a Guarantor pursuant to Section 6.13, together with their successors and permitted assigns.

"Guarantee" means, as to any Person, (a) any obligation, contingent or otherwise, of such Person guaranteeing or having the economic effect of guaranteeing any Indebtedness or other obligation payable or performable by another Person (the "primary obligor") in any manner, whether directly or indirectly, and including any obligation of such Person, direct or indirect, (i) to purchase or pay (or advance or supply funds for the purchase or payment of) such Indebtedness or other obligation, (ii) to purchase or lease property, securities or services for the purpose of assuring the obligee in respect of such Indebtedness or other obligation of the payment or performance of such Indebtedness or other obligation, (iii) to maintain working capital, equity capital or any other financial statement condition or liquidity or level of income or cash flow of the primary obligor so as to enable the primary obligor to pay such Indebtedness or other obligation, or (iv) entered into for the purpose of assuring in any other manner the obligee in respect of such Indebtedness or other obligation of the payment or performance thereof or to protect such obligee against loss in respect thereof (in whole or in part), or (b) any Lien on any assets of such Person securing any Indebtedness or other obligation of any other Person, whether or not such Indebtedness or other obligation is assumed by such Person; provided that Guarantee shall not include endorsements for collection or deposits in the ordinary course of business. The amount of any Guarantee shall be deemed to be an amount equal to the stated or determinable amount of the related primary obligation, or portion thereof, in respect of which such Guarantee is made or, if not stated or determinable, the maximum reasonably anticipated liability in respect thereof as determined by the guaranteeing Person in good faith. The term "Guarantee" as a verb has a corresponding meaning.

"Hazardous Materials" means all explosive or radioactive substances or wastes and all hazardous or toxic substances, wastes or other pollutants, including petroleum or petroleum distillates, asbestos or asbestos-containing materials, polychlorinated biphenyls, radon gas, infectious or medical wastes and all other substances or wastes of any nature regulated pursuant to any Environmental Law.

"HHS" means the United States Department of Health and Human Services and any successor thereof.

"HMO" means any health maintenance organization or similar managed care organization, or any health service plan under California Law, any Person doing business as a health maintenance organization or similar managed care organization, or a health care service plan under California Law, or any Person required to qualify or be licensed as a health maintenance organization or similar managed care organization under applicable federal or state Law or a health care service plan under California Law (including, without limitation, in each case, HMO Regulations).

"HMO Business" means the business of owning and operating an HMO.

"HMO Event" means (a) any material non-compliance by the Borrower or any of the Subsidiaries to the extent subject to HMO Regulations with any of the terms and provisions of the HMO Regulations pertaining to its fiscal soundness, solvency or financial condition, or (b) the assertion in writing, after the date hereof, by an HMO Regulator that it intends to take administrative action against the Borrower or any of the Subsidiaries to revoke or modify in a material and adverse manner any license, charter or permit or (c) the commencement of proceedings against the Borrower or any of its Subsidiaries in which an HMO Regulator asserts that the Borrower or any Subsidiary has failed to comply with the soundness, solvency or financial provisions or requirements of the HMO Regulations.

"HMO Model Act" means the Health Maintenance Organization Model Act adopted by the National Association of Insurance Commissioners.

"HMO Regulations" means all laws, regulations, directives and administrative orders applicable under federal or state law or the law of the District of Columbia to any HMO Subsidiary (and any regulations, orders and directives promulgated or issued pursuant to any of the foregoing) and Subchapter XI of Chapter 6A of Title 42 of the United States Code Annotated (and any regulations, orders and directives promulgated or issued pursuant thereto, including, without limitation, Part 417 of Chapter IV of 42 Code of Federal Regulations (1990)).

"HMO Regulator" means any Governmental Authority charged with the administration, oversight or enforcement of an HMO Regulation, whether primarily, secondarily or jointly.

"HMO Subsidiary" means each of the Subsidiaries identified as an HMO Subsidiary on Schedule 5.08 hereto, and any other existing or future Subsidiary that is licensed as an HMO, conducting HMO Business and/or providing managed care services.

"Honor Date" has the meaning specified in Section 2.03(c)(i).

"Improvements" shall mean, with respect to any Mortgaged Property, all buildings, structures and other improvements now or hereafter existing, erected or placed on or under the Mortgaged Property or any portion thereof, and all fixtures of every kind and nature whatsoever now or hereafter owned and used or procured for use in connection with the Mortgaged Property.

"Indebtedness" means, as to any Person at a particular time, without duplication, all of the following, whether or not included as indebtedness or liabilities in accordance with GAAP:

(a) all obligations of such Person for borrowed money and all obligations of such Person evidenced by bonds, debentures, notes, loan agreements or other similar instruments;

(b) all direct or contingent obligations of such Person arising under letters of credit (including standby and commercial), bankers' acceptances, bank guaranties, surety bonds and similar instruments;

(c) the net obligations of such Person under any Swap Contract;

(d) all obligations of such Person to pay the deferred purchase price of property or services (other than trade accounts payable in the ordinary course of business;

(e) indebtedness (excluding prepaid interest thereon) secured by a Lien on property owned or being purchased by such Person (including indebtedness arising under conditional sales or other title retention agreements), whether or not such indebtedness shall have been assumed by such Person or is limited in recourse;

(f) Capitalized Leases;

(g) all obligations of such Person to purchase, redeem, retire, defease or otherwise make any payment in respect of any equity interests in such Person or any other Person or any warrants, rights or options to acquire such equity interests, valued in the case of redeemable preferred interests, at the greater of its voluntary or involuntary liquidation preference plus accrued and unpaid dividends;

(h) all Indebtedness in respect of any of the foregoing of another Person secured by (or for which the holder of such Indebtedness has an existing right, contingent or otherwise, to be secured by) any Lien on the property (including, without limitation, accounts and contract rights) owned by such Person, even though such Person has not assumed or become liable for such Indebtedness; and

(i) all Guarantees of such Person in respect of any of the foregoing.

For all purposes hereof, the Indebtedness of any Person shall include the Indebtedness of any partnership or joint venture (other than a joint venture that is itself a corporation or limited liability company) in which such Person is a general partner or a joint venturer, unless such Indebtedness is expressly made non-recourse to such Person. The amount of any net obligation under any Swap Contract on any date shall be deemed to be the Swap Termination Value thereof as of such date. The amount of any Capitalized Lease as of any date shall be deemed to be the amount of Attributable Indebtedness in respect thereof as of such date.

"Indemnified Liabilities" has the meaning specified in Section 10.05.

"Indemnitees" has the meaning specified in Section 10.05.

"Information" has the meaning specified in Section 10.08.

"Intellectual Property Collateral" has the meaning specified in the Security Agreement.

"Intercompany Note" means the promissory notes issued as contemplated by Section 7.02(d), substantially in the form of Exhibit A to the Pledge Agreement.

"Interest Charges" means, for any period for any Person, the sum of (a) all interest, premium payments, debt, discount, fees, charges and related expenses in connection with Indebtedness for borrowed money (including capitalized interest) or in connection with the deferred purchase price of assets, in each case to the extent treated as interest in accordance with GAAP, and (b) the portion of rent expense with respect to such period under Capitalized Leases that is treated as interest in accordance with GAAP.

"Interest Payment Date" means (a) as to any Eurodollar Rate Loan, the last day of each Interest Period applicable to such Loan and the Maturity Date; provided, however, that if any Interest Period for a Eurodollar Rate Loan exceeds three months, the respective dates that fall every three months after the beginning of such Interest Period shall also be Interest Payment Dates; and (b) as to any Base Rate Loan, the last Business Day of each March, June, September and December and the Maturity Date.

"Interest Period" means, as to each Eurodollar Rate Loan, the period commencing on the date such Eurodollar Rate Loan is disbursed or converted to or continued as a Eurodollar Rate Loan and ending on the date one, two, three or six months thereafter, as selected by the Borrower in its Loan Notice; provided that:

(i) any Interest Period that would otherwise end on a day that is not a Business Day shall be extended to the next succeeding Business Day unless such Business Day falls in another calendar month, in which case such Interest Period shall end on the immediately preceding Business Day;

(ii) any Interest Period that begins on the last Business Day of a calendar month (or on a day for which there is no numerically corresponding day in the calendar month at the end of such Interest Period) shall end on the last Business Day of the calendar month at the end of such Interest Period; and

(iii) no Interest Period shall extend beyond the Maturity Date.

"Investment" means, as to any Person, any direct or indirect acquisition or investment by such Person, whether by means of (a) the purchase or other acquisition of capital stock or other securities of another Person, (b) a loan, advance or capital contribution to, Guarantee or assumption of debt of, or purchase or other acquisition of, any other debt or equity participation or interest in, another Person, including any partnership or joint venture interest in such other Person, or (c) the purchase or other acquisition (in one transaction or a series of transactions) of assets of another Person that constitute a business unit. For purposes of covenant compliance at the particular time in question, the amount of any Investment shall be the amount actually invested, without adjustment for subsequent increases or decreases in the value of such Investment.

"IP Rights" has the meaning set forth in Section 5.10.

"IRS" means the United States Internal Revenue Service.

"Joinder Agreement" means a joinder agreement executed and delivered in accordance with the provisions of Sections 6.13 and 6.14, substantially in the form of Exhibit E hereto.

"Laws" means, collectively, all international, foreign, Federal, state and local statutes, treaties, rules, guidelines, regulations, ordinances, codes and administrative or judicial precedents or authorities, including the interpretation or administration thereof by any Governmental Authority charged with the enforcement, interpretation or administration thereof, and all applicable administrative orders, directed duties, requests, licenses, authorizations and permits of any Governmental Authority.

"L/C Advance" means, with respect to each Lender, such Lender's funding of its participation in any L/C Borrowing in accordance with its Pro Rata Share.

"L/C Borrowing" means an extension of credit resulting from a drawing under any Letter of Credit which has not been reimbursed by the Borrower on the Honor Date or refinanced as a Borrowing.

"L/C Credit Extension" means, with respect to any Letter of Credit, the issuance thereof or extension of the expiry date thereof, or the renewal or increase of the amount thereof.

"L/C Issuer" means Bank of America in its capacity as issuer of Letters of Credit hereunder, or any successor issuer of Letters of Credit hereunder.

"L/C Obligations" means, as at any date of determination, the aggregate undrawn amount of all outstanding Letters of Credit plus the aggregate of all Unreimbursed Amounts, including all L/C Borrowings.

"Lender" has the meaning specified in the introductory paragraph hereto and, as the context requires, includes each Lender with a commitment to make Loans as designated in Section 2.01 or in an Assignment and Assumption Agreement or a joinder pursuant to which such Lender becomes a party hereto and the L/C Issuer.

"Lending Office" means, as to any Lender, the office or offices of such Lender described as such in such Lender's Administrative Questionnaire, or such other office or offices as to which a Lender may from time to time notify the Borrower and the Administrative Agent.

"Letter of Credit" means a commercial letter of credit or a standby letter of credit issued hereunder.

"Letter of Credit Application" means an application and agreement for the issuance or amendment of a Letter of Credit in the form from time to time in use by the L/C Issuer.

"Letter of Credit Expiration Date" means the day that is seven days prior to the Maturity Date then in effect (or, if such day is not a Business Day, the immediately preceding Business Day).

"Letter of Credit Sublimit" means an amount equal to the lesser of (a) $10 million and (b) the unused amount of the Aggregate Commitments at such time. The Letter of Credit Sublimit is part of, and not in addition to, the Aggregate Commitments.

"Lien" means any mortgage, pledge, hypothecation, assignment, deposit arrangement, encumbrance, lien (statutory or other), charge, or preference, priority or other security interest or preferential arrangement of any kind or nature whatsoever (including any conditional sale or other title retention agreement, and any financing lease having substantially the same economic effect as any of the foregoing).

"Loan" means an extension of credit by a Lender to the Borrower under Article II in the form of a Loan.

"Loan Documents" means this Agreement, the Notes, the Fee Letter, each Letter of Credit Application, the Subsidiary Guaranty, Secured Swap Contract, the Collateral Documents and all other documents delivered to the Administrative Agent or any Lender in connection herewith or therewith.

"Loan Notice" means a notice of (a) a Borrowing, (b) a conversion of Loans from one Type to the other, or (c) a continuation of Eurodollar Rate Loans, pursuant to Section 2.02(a), which, if in writing, shall be substantially in the form of Exhibit A hereto.

"Loan Parties" means, collectively, the Borrower and each Guarantor.

"Master Agreement" has the meaning specified in the definition of "Swap Contract".

"Material Adverse Effect" means (a) a material adverse change in, or a material adverse effect on, (a) the operations, business, properties, liabilities (actual or contingent) or condition (financial or otherwise) of the Borrower or Subsidiaries taken as a whole, (b) the ability of any Loan Party to perform its obligations under any Loan Document to which it is a party, (c) the Lien of any Collateral Document, or (d) the material rights, powers, or remedies of the Administrative Agent or any Lender under any Loan Document.

"Material Contract" means, with respect to the Borrower and the Subsidiaries, (a) the contracts set forth on Schedule 5.24, (b) each credit agreement, capital lease or other agreement related to any Indebtedness of the Borrower and the Subsidiaries in an amount greater than $5 million (other than the Loan Documents), (c) each Swap Contract to which the Borrower or any of the Subsidiaries is a party, (d) any voting or shareholder's agreement related to the equity interest in any Person to which the Borrower or any of the Subsidiaries is a party, and (e) any other contract to which any such Person is a party involving aggregate consideration payable to or by such Person of $5 million or more in any year or otherwise material to the business, condition (financial or otherwise), operations, performance, properties of the Borrower and the

Subsidiaries, taken as a whole; provided, however, that agreements entered into in connection with a Permitted Acquisition shall be excluded from this definition.

"Maturity Date" means March 20, 2006.

"Medicaid" means that means-tested entitlement program under Title XIX, P.L. 89-87 of the Social Security Act, which provides federal grants to states for medical assistance based on specific eligibility criteria, as set forth on Section 1396, et seq. of Title 42 of the United States Code, as amended.

"Medicaid Regulations" means, collectively, (a) all federal statutes (whether set forth in Title XIX of the Social Security Act or elsewhere) affecting the medical assistance program established by Title XIX of the Social Security Act and any statutes succeeding thereto, (b) all applicable provisions of all federal rules, regulations, manuals and orders of all Governmental Authorities promulgated pursuant to or in connection with the statutes described in subsection (a) above and all federal administrative, reimbursement and other guidelines of all Governmental Authorities having the force of law promulgated pursuant to or in connection with the statutes described in subsection (a) above, (c) all state or other political subdivision statutes and regulations for medical assistance enacted in connection with the statutes and provisions described in subsections (a) and (b) above, and (d) all applicable provisions of all rules, regulations, manuals and orders of all Governmental Authorities promulgated pursuant to or in connection with the statutes described in clause (iii) above and all state administrative, reimbursement and other guidelines of all Governmental Authorities having the force of law promulgated pursuant to or in connection with the statutes described in subsection (b) above, in each case as may be amended, supplemented or otherwise modified from time to time.

"Medical Reimbursement Programs" means a collective reference to the Medicare, Medicaid and CHAMPUS programs and any other health care program operated by or financed in whole or in part by any Governmental Authority.

"Medicare" means that government-sponsored entitlement program under Title XVIII, P.L. 89-87, of the Social Security Act, which provides for a health insurance system for eligible elderly and disabled individuals, as set forth at Section 1395, et seq. of Title 42 of the United States Code, as amended.

"Medicare Regulations" means, collectively, all federal statutes (whether set forth in Title XVIII of the Social Security Act or elsewhere) affecting the health insurance program for the aged and disabled established by Title XVIII of the Social Security Act and any statutes succeeding thereto, together with all applicable provisions of all rules, regulations, manuals and orders and administrative, reimbursement and other guidelines having the force of law of all applicable provisions of all rules, regulations, manuals and orders and administrative, reimbursement and other guidelines having the force of law of all Governmental Authorities (including, without limitation, CMS, the OIG, HHS, or any person succeeding to the functions of the foregoing) promulgated pursuant to or in connection with any of the foregoing having the force of law, as each may be amended, supplemented or otherwise modified from time to time.

"Molina Family" means Mary R. Molina, Joseph M. Molina, Mary Martha Bernadett, M.D., John C. Molina, Janet M. Watt and Josephine M. Battiste, and the spouses, natural and legal issue and other descendants and the stepchildren (including the natural and legal issue of the stepchildren) of any of the above-named persons.

"Molina Healthcare of California" means Molina Healthcare of California, a California corporation.

"Molina Healthcare of Michigan" means Molina Healthcare of Michigan, Inc., a Michigan corporation.

"Molina Healthcare of Utah" means Molina Healthcare of Utah, Inc., d.b.a. American Family Care of Utah, a Utah corporation.

"Molina Healthcare of Washington" means Molina Healthcare of Washington, Inc., a Washington corporation.

"Mortgage" means a mortgage, deed of trust, assignment of leases and rents, leasehold mortgage or other security document granting a security interest to the Administrative Agent on the Mortgaged Property, substantially in the form of Exhibit J hereto or in such form as is suitable for filing in the applicable jurisdiction.

"Mortgaged Property" means (a) all Real Property Assets identified on Schedule 5.11 that are identified as Mortgaged Property and (b) all other Real Property Assets with respect to which a Mortgage is granted pursuant to Section 6.15.

"Multiemployer Plan" means any employee benefit plan of the type described in Section 4001(a)(3) of ERISA, to which the Borrower or any ERISA Affiliate makes or is obligated to make contributions, or during the preceding five plan years, has made or has been obligated to make contributions.

"NAIC" means the National Association of Insurance Commissioners, a national organization of insurance regulators.

"Net Dividends" means, for any period, dividends paid by the HMO Subsidiaries to the Borrower, minus cash Investments made by the Borrower in the HMO Subsidiaries.

"Net Income" means, for any period, net income of any Person (excluding extraordinary gains but including extraordinary cash losses) for that period.

"Note" means a promissory note made by the Borrower in favor of a Lender evidencing Loans made by such Lender, substantially in the form of Exhibit B hereto.

"Obligations" means all advances to, and debts, liabilities, obligations, covenants and duties of, any Loan Party arising under any Loan Document (including any Secured Swap Contract entered into after the date of this Agreement) or otherwise with respect to any Loan or Letter of Credit, whether direct or indirect (including those acquired by assumption), absolute or contingent, due or to become due, now existing or hereafter arising and including interest and

fees that accrue after the commencement by or against any Loan Party or any Affiliate thereof of any proceeding under any Debtor Relief Laws naming such Person as the debtor in such proceeding, regardless of whether such interest and fees are allowed claims in such proceeding. Without limiting the generality of the foregoing, the Obligations of the Borrower under the Loan Documents include (a) the obligation to pay principal, interest, Letter of Credit commissions, charges, expenses, fees, Attorney Costs and disbursements, indemnities and other amounts payable by the Borrower under any Loan Document and (b) the obligations of the Borrower to reimburse any amount in respect of any of the foregoing that any Lender, in its reasonable discretion, may elect to pay or advance on behalf of the Borrower.

"OIG" means the Office of Inspector General of HHS and any successor thereof.

"Operating Lease" means, as applied to any Person, any lease (including, without limitation, leases that may be terminated by the lessee at any time) of any Property that is not a Capitalized Lease other than any such lease in which that Person is the lessor.

"Organization Documents" means (a) with respect to any corporation, the certificate or articles of incorporation and the bylaws, (b) with respect to any limited liability company, the certificate or articles of formation or organization and operating agreement, and (c) with respect to any partnership, joint venture, trust or other form of business entity, the partnership, joint venture or other applicable agreement of formation or organization and any agreement, instrument, filing or notice with respect thereto filed in connection with its formation or organization with the applicable Governmental Authority in the jurisdiction of its formation or organization and, if applicable, any certificate or articles of formation or organization of such entity.

"Other Taxes" has the meaning specified in Section 3.01(b).

"Outstanding Amount" means (a) with respect to Loans on any date, the aggregate outstanding principal amount thereof after giving effect to any borrowings and prepayments or repayments of Loans occurring on such date, and (b) with respect to any L/C Obligations on any date, the amount of such L/C Obligations on such date after giving effect to any L/C Credit Extension occurring on such date and any other changes in the aggregate amount of the L/C Obligations as of such date, including as a result of any reimbursements of outstanding unpaid drawings under any Letters of Credit or any reductions in the maximum amount available for drawing under Letters of Credit taking effect on such date.

"Participant" has the meaning specified in Section 10.07(d).

"PBGC" means the Pension Benefit Guaranty Corporation.

"Pension Plan" means any "employee pension benefit plan" (as such term is defined in Section 3(2) of ERISA), other than a Multiemployer Plan, that is subject to Title IV of ERISA and is sponsored or maintained by the Borrower or any ERISA Affiliate or to which the Borrower or any ERISA Affiliate contributes or has an obligation to contribute, or in the case of a multiple employer or other plan described in Section 4064(a) of ERISA, has made contributions at any time during the immediately preceding five plan years.

"Permitted Acquisitions" means any Acquisition by the Borrower, any other Loan Party or any wholly-owned Subsidiary of the Borrower whose stock is pledged pursuant to the Pledge Agreement (for purposes hereof, an "Acquiring Party"); provided that (a) the Person to be acquired is a direct or indirect wholly-owned Subsidiary of the Borrower and is in the HMO Business or a healthcare services-related business, (b) the Property acquired (or the Property of the Person acquired) in such Acquisition shall be used or useful in the same or similar line of business as the Borrower and the Subsidiaries on the Closing Date, (c) all Property to be acquired in connection with such Acquisition shall be located in the United States of America, (d) in the case of an Acquisition of the capital stock of another Person, the board of directors (or other comparable governing body) of such other Person shall have duly approved such Acquisition, (e) no Default shall exist immediately after giving effect to such Acquisition on a Pro Forma Basis, (f) the Acquisition shall not involve an interest in a partnership or have a requirement that the Borrower or any other Loan Party be a general partner or involve a partial interest in any entity or joint venture interest, (g) the Acquiring Party shall, and shall cause the party that is the subject of the Acquisition to, execute and deliver such joinder and pledge agreements, security agreements and intercompany notes and take such other actions as may be necessary for compliance with the provisions of Sections 6.13, 6.14 and 6.15, (h)(i) for each Acquisition (or a series of related Acquisitions) the aggregate consideration (including for purposes of consideration (A) cash consideration, (B) non-cash consideration (including any assumed debt) and (C) for such Person to be acquired, an amount determined by the Acquiring Party in good faith at the time of the Acquisition of projected capital infusions required by Governmental Authorities or necessary in order to maintain compliance by such Person with the provisions of this Agreement as of the end of that fiscal year) (excluding for purposes of such calculation, the fair market value of any capital stock or other equity interest of the Borrower issued as part of the consideration for any such Acquisition) is less than or equal to the amount determined pursuant to the table below, (ii) for all Acquisitions, the aggregate consideration in a fiscal year (including for purposes of consideration (A) cash consideration, (B) non-cash consideration (including any assumed debt) and (C) for such Person to be acquired, an amount determined by the Acquiring Party in good faith at the time of the Acquisition of projected capital infusions required by Governmental Authorities or necessary in order to maintain compliance by such Person with the provisions of this Agreement as of the end of that fiscal year) (excluding for purposes of such calculation, the fair market value of any capital stock or other equity interest of the Borrower issued as part of the consideration for any such Acquisition) is less than or equal to the amount determined pursuant to the table below, and (i) the Borrower shall have delivered to the Administrative Agent (A) a Compliance Certificate signed by Responsible Officers of the Borrower demonstrating compliance with the financial covenants hereunder after giving effect to the subject Acquisition on a Pro Forma Basis and compliance with clauses (g) and (h) above, and reaffirming that the representations are true and correct in all material respects as of such date and providing supplements to the Schedules as required by the Compliance Certificate and (B) a certificate of a Responsible Officer of the Borrower describing the Person to be acquired, including, without limitation, the location and type of operations, key management and HMO assets of such Person, if any; provided, however, that the Acquisition shall not result in interests in such Person or the property of such Person being directly or indirectly held by or transferred into Molina Healthcare of California or any of its Subsidiaries so long as the stock of Molina Healthcare of California has not been pledged pursuant to terms of this Agreement and, so long as Molina Healthcare of Michigan is a wholly-owned Subsidiary of

Molina Healthcare of California, into Molina Healthcare of Michigan and its Subsidiaries, except that Molina Healthcare of California and its Subsidiaries located in California and Molina Healthcare of Michigan so long as it is a wholly-owned Subsidiary of Molina Healthcare of California and its Subsidiaries, shall be permitted to make one or more Acquisitions in accordance with the provisions set forth in this definition but solely within the States of California and, while Molina Healthcare of Michigan is wholly owned by Molina Healthcare of California, Michigan, where the consideration therefor is payable (x) solely in the form of common stock of the Borrower or (y) in the form of cash and non-cash consideration in an amount equal to 50% of the amounts set forth in the table below for less than 1.0 times in accordance with clauses (h)(i) and (ii) above, but only if the Consolidated Leverage Ratio is less than 1.0 times; provided that for purposes of clarification the aforementioned sublimits in the proviso shall apply to Molina Healthcare of California and its Subsidiaries and Molina Healthcare of Michigan, so long as it is a wholly-owned Subsidiary of Molina Healthcare of California, and its Subsidiaries and shall reduce the limits stated in the table below by the amount of any cash consideration paid for any such Acquisition.

	PRE-SUCCESSFUL IPO		POST-SUCCESSFUL IPO	
Consolidated Leverage Ratio	Each Acquisition	All Acquisitions in a Fiscal Year in the Aggregate	Each Acquisition	All Acquisitions in a Fiscal Year in the Aggregate
>= 1.0	$10 million	$20 million	$15 million	$30 million
<= 1.0	$15 million	$30 million	$20 million	$40 million

"Permitted Lien" has the meaning specified in Section 7.01.

"Permitted Stock Redemptions/ESOP Transactions" means the redemption by the Borrower of outstanding shares of its common stock and purchases of outstanding shares of the Borrower's common stock by an employee stock ownership plan, in each case from MRM GRAT 301/2, Mary Martha Molina Trust (1995), Janet Marie Watt Trust (1995), Josephine M. Molina Trust (1995), Mary R. Molina Living Trust, Molina Marital Trust and Mary Martha Bernadett, M.D.; provided that (a) the stock redemption portion of the Permitted Stock Redemptions/ESOP Transactions was completed on February 19, 2003, and the ESOP portion of the Permitted Stock Redemptions/ESOP Transactions shall be completed no later than September 30, 2003, (b) shall be for consideration of no more than $40 million in the aggregate and shall comply with the requirements of Section 6.12 and (c) shall be on terms reasonably satisfactory to the Administrative Agent and the Required Lenders.

"Person" means any natural person, corporation, limited liability company, trust, joint venture, association, company, partnership, Governmental Authority or other entity.

"Plan" means any "employee benefit plan" (as such term is defined in Section 3(3) of ERISA) established by the Borrower or, with respect to any such plan that is subject to Section 412 of the Code or Title IV of ERISA, any ERISA Affiliate.

"Pledge Agreement" means the Pledge Agreement executed by the Borrower and any Subsidiary party thereto, which Pledge Agreement shall be substantially in the form of Exhibit G hereto.

"Property" means any interest in any kind of property or asset, whether real, personal or mixed, or tangible or intangible.

"Pro Forma Basis" means, for purposes of determining the applicable pricing level under the definition of "Applicable Rate," and determining compliance with any financial covenant or test hereunder and determining whether the conditions precedent to a Permitted Acquisition have been met, that the subject transaction shall be deemed to have occurred as of the first day of the period of four consecutive fiscal quarters ending as of the end of the most recent fiscal quarter for which annual or quarterly financial statements shall have been delivered in accordance with the provisions hereof (the "Reference Period"). Further, for purposes of making calculations on a "Pro Forma Basis" hereunder, (a) any funds to be used by any Person in consummating a Permitted Acquisition will be assumed to have been used for that purpose as of the first day of the Reference Period, (b) EBITDA and EBITDAR for the Reference Period associated with the assets acquired or to be acquired in any Permitted Acquisition will be included in the calculation of Consolidated EBITDA and EBITDAR, (c) any Indebtedness to be incurred by any Person in connection with the consummation of any Permitted Acquisition will be assumed to have been incurred on the first day of the Reference Period, (d) the gross interest expenses, determined in accordance with GAAP, with respect to such Indebtedness assumed to have been incurred on the first day of the Reference Period that bears interest at a floating rate shall be calculated at the current rate under the agreement governing such Indebtedness (including this Agreement if the Indebtedness is incurred hereunder), and (e) any gross interest expense, determined in accordance with GAAP, incurred during the Reference Period that was or is to be refinanced with proceeds of Indebtedness assumed to have been incurred as of the first day of the Reference Period will be excluded from the calculation for which a Pro Forma Basis is being given.

"Pro Rata Share" means, with respect to each Lender at any time, a fraction (expressed as a percentage, carried out to the ninth decimal place), the numerator of which is the amount of the Commitment of such Lender at such time and the denominator of which is the amount of the Aggregate Commitments at such time; provided that if the commitment of each Lender to make Loans and the obligation of the L/C Issuer to make L/C Credit Extensions have been terminated pursuant to Section 8.02, then the Pro Rata Share of each Lender shall be determined based on the Pro Rata Share of such Lender immediately prior to such termination and after giving effect to any subsequent assignments made pursuant to the terms hereof. The initial Pro Rata Share of each Lender is set forth opposite the name of such Lender on Schedule 2.01 or in the Assignment and Assumption pursuant to which such Lender becomes a party hereto, as applicable.

"Real Property Assets" means all interest (including leasehold interests) of the Borrower and any Eligible Subsidiary in any real property.

"Register" has the meaning specified in Section 10.07(c).

"Reincorporation Merger Documents" means that certain Agreement of Merger by and between Molina Healthcare, Inc., a California corporation, and Molina Healthcare, Inc., a Delaware corporation, in the form attached hereto as Schedule 7.04 with any non-substantive and non-material technical corrections thereto mandated by the applicable California or Delaware regulatory authorities, and that certain Certificate of Merger merging Molina Healthcare, Inc., a California corporation, into Molina Healthcare, Inc., a Delaware corporation, in the form attached hereto as Schedule 7.04 with any non-substantive and non-material technical corrections thereto mandated by the applicable California or Delaware regulatory authorities.

"Rental Expense" means, for any period of determination, for any Person, the gross rental expenses for such period.

"Reportable Event" means any of the events set forth in Section 4043(c) of ERISA, other than events for which the 30 day notice period has been waived.

"Request for Credit Extension" means (a) with respect to a Borrowing, conversion or continuation of Loans, a Loan Notice, and (b) with respect to an L/C Credit Extension, a Letter of Credit Application.

"Required Advances" means advances required by HMO Regulators to be made by the Borrower or any of the Subsidiaries to a Contract Provider; provided that the Borrower shall have provided reasonably satisfactory evidence of any such requirement to the Administrative Agent.

"Required Lenders" means, as of any date of determination, at least three Lenders having more than 50% of the Aggregate Commitments or, if the commitment of each Lender to make Loans and the obligation of the L/C Issuer to make L/C Credit Extensions have been terminated pursuant to Section 8.02, or otherwise, at least three Lenders holding in the aggregate more than 50% of the Total Outstandings (with the aggregate amount of each Lender's risk participation and funded participation in L/C Obligations being deemed "held" by such Lender for purposes of this definition); provided that the Commitment of, and the portion of the Total Outstandings held or deemed held by, any Defaulting Lender shall be excluded for purposes of making a determination of Required Lenders.

"Responsible Officer" means the chief executive officer, president, chief financial officer, or treasurer of any Person. Any document delivered hereunder that is signed by a Responsible Officer of a Loan Party shall be conclusively presumed to have been authorized by all necessary corporate, partnership and/or other action on the part of such Loan Party and such Responsible Officer shall be conclusively presumed to have acted on behalf of such Loan Party.

"Restricted Payment" means any dividend or other distribution (whether in cash, securities or other property) with respect to any capital stock or other equity interest of the Borrower or any of the Subsidiaries (including, without limitation, any payment in connection with any dissolution, merger, consolidation or disposition involving the Borrower or any of the Subsidiaries), and any redemption, retirement, cancellation, termination, payment in any sinking

fund or similar payment, purchase, or other acquisition of any such capital stock or other equity interest or of any option, warrant or other right to acquire any such capital stock or other equity interest or on account of any warrant or other right to acquire any such capital stock or other equity interest, or on account of any return of capital to the Borrower's or any of the Subsidiaries' stockholders, partners or members (or the equivalent Persons thereof) or the issuance of any equity interest or acceptance of any capital contributions.

"Risk-Based Capital" means, with respect to each HMO Subsidiary, at any time, the Company Action Level Risk-Based Capital (as defined by the NAIC on the date of determination and as determined in accordance with SAP) of such HMO Subsidiary.

"SAP" means, with respect to each HMO Subsidiary, the statutory accounting principles and procedures prescribed or permitted by applicable HMO Regulations for such HMO Subsidiary, applied on a consistent basis.

"Sarbanes-Oxley" means the Sarbanes-Oxley Act of 2002.

"SEC" means the Securities and Exchange Commission, or any Governmental Authority succeeding to any of its principal functions.

"Secured Obligations" has the meaning specified in Section 2.2 of the Security Agreement.

"Secured Party" means the Administrative Agent, each Lender and each Swap Bank.

"Secured Swap Contract" means any Swap Contract required or permitted under this Agreement that is entered into by and between the Borrower and any Swap Bank.

"Securitization Transaction" means any financing transaction or series of financing transactions, including factoring transactions, that have been or may be entered into by the Borrower or any of its Subsidiaries pursuant to which such Person may sell, convey or otherwise transfer to (i) a Subsidiary or Affiliate of such Person, or (ii) any other Person, or may grant a security interest in, any accounts receivable, notes receivable, rights to future lease payments or residuals or other similar rights to payment (the "Securitization Receivables") (whether such Securitization Receivables are then existing or arising in the future) of the Borrower or such Subsidiary, as applicable, and any assets related thereto, including, without limitation, all security interests in merchandise or services financed thereby, the proceeds of such Securitization Receivables, and other assets that are customarily sold or in respect of which security interests are customarily granted in connection with securitization or factoring transactions involving such assets.

"Security Agreement" means the Security Agreement executed by the Borrower and each Eligible Subsidiary, substantially in the form of Exhibit H hereto.

"Shareholders' Equity" means, as of any date of determination, consolidated shareholders' equity of the Borrower and the Subsidiaries as of that date determined in accordance with GAAP.

"Social Security Act" means the Social Security Act of 1965 as set forth in Title 42 of the United States Code, as amended, and any successor statute thereto, as interpreted by the rules and regulations issued thereunder, in each case as in effect from time to time. References to sections of the Social Security Act shall be construed to refer to any successor sections.

"Stark I and II" means Section 1877 of the Social Security Act as set forth at Section 1395nn of Title 42 of the United States Code, as amended, and any successor statute thereto, as interpreted by the rules and regulations issued thereunder, in each case as in effect from time to time.

"Subject Properties" has the meaning specified in Section 5.12(a).

"Subsidiary" of a Person means a corporation, partnership, joint venture, limited liability company or other business entity which is organized under the Laws of a political subdivision of the United States of which a majority of the shares of securities or other interests having ordinary voting power for the election of directors or other governing body (other than securities or interests having such power only by reason of the happening of a contingency) are at the time beneficially owned, or the management of which is otherwise controlled, directly, or indirectly through one or more intermediaries, or both, by such Person. Unless otherwise specified, all references herein to a "Subsidiary" or to "Subsidiaries" shall refer to a Subsidiary or Subsidiaries of the Borrower.

"Subsidiary Guaranty" means the Subsidiary Guaranty Agreement duly executed by each Guarantor, substantially in the form of Exhibit I hereto.

"Successful IPO" means an initial public offering of the capital stock of the Borrower which results in net cash proceeds to the Borrower of at least $50 million.

"Swap Bank" means any Lender or an Affiliate of a Lender in its capacity as a party to a Swap Contract entered into after the date of this Agreement.

"Swap Contract" means (a) any and all rate swap transactions, basis swaps, credit derivative transactions, forward rate transactions, commodity swaps, commodity options, forward commodity contracts, equity or equity index swaps or options, bond or bond price or bond index swaps or options or forward bond or forward bond price or forward bond index transactions, interest rate options, forward foreign exchange transactions, cap transactions, floor transactions, collar transactions, currency swap transactions, cross-currency rate swap transactions, currency options, spot contracts, or any other similar transactions or any combination of any of the foregoing (including any options to enter into any of the foregoing), whether or not any such transaction is governed by or subject to any master agreement, and (b) any and all transactions of any kind, and the related confirmations, which are subject to the terms and conditions of, or governed by, any form of master agreement published by the International Swaps and Derivatives Association, Inc., any International Foreign Exchange Master Agreement, or any other master agreement (any such master agreement, together with any related schedules, a "Master Agreement"), including any such obligations or liabilities under any Master Agreement.

"Swap Termination Value" means, in respect of any one or more Swap Contracts, after taking into account the effect of any legally enforceable netting agreement relating to such Swap Contracts, (a) for any date on or after the date such Swap Contracts have been closed out and termination value(s) determined in accordance therewith, such termination value(s), and (b) for any date prior to the date referenced in clause (a), the amount(s) determined as the mark-to-market value(s) for such Swap Contracts, as determined based upon one or more mid-market or other readily available quotations provided by any recognized dealer in such Swap Contracts (which may include a Lender or any Affiliate of a Lender).

"Syndication Agent" means CIBC World Markets Corp. in its capacity as syndication agent under any of the Loan Documents, or any successor syndication agent.

"Taxes" has the meaning specified in Section 3.01(a).

"Threshold Amount" means $5 million.

"Title Insurance Company" has the meaning specified in Section 6.15(b)(ii).

"Total Adjusted Capital" means, with respect to each HMO Subsidiary, at any time, the Total Adjusted Capital (as defined by the NAIC on the date of determination and as determined in accordance with SAP) of such HMO Subsidiary.

"Total Outstandings" means the aggregate Outstanding Amount of all Loans and all L/C Obligations.

"Type" means, with respect to a Loan, its character as a Base Rate Loan or a Eurodollar Rate Loan.

"UCC" means the Uniform Commercial Code.

"Unfunded Pension Liability" means the excess of a Pension Plan's benefit liabilities under Section 4001(a)(16) of ERISA, over the current value of that Pension Plan's assets, determined in accordance with the assumptions used for funding the Pension Plan pursuant to Section 412 of the Code for the applicable plan year.

"United States" and "U.S." mean the United States of America.

"Unreimbursed Amount" has the meaning specified in Section 2.03(c)(i).

"Waiver Agreement" means, collectively, the Waiver Agreements, each substantially in the form of Exhibit C to the Security Agreement.

Section 1.02 Other Interpretive Provisions. With reference to this Agreement and each other Loan Document, unless otherwise specified herein or in such other Loan Document:

(a) The meanings of defined terms are equally applicable to the singular and plural forms of the defined terms.

(b) (i) The words "herein," "hereto," "hereof" and "hereunder" and words of similar import when used in any Loan Document shall refer to such Loan Document as a whole and not to any particular provision thereof.

(ii) Article, Section, Exhibit and Schedule references are to the Loan Document in which such reference appears.

(iii) The term "including" is by way of example and not limitation.

(c) The term "documents" includes any and all instruments, documents, agreements, certificates, notices, reports, financial statements and other writings, however evidenced, whether in physical or electronic form.

(d) In the computation of periods of time from a specified date to a later specified date, the word "from" means "from and including;" the words "to" and "until" each mean "to but excluding;" and the word "through" means "to and including."

(e) Each reference to "basis points" or "bps" shall be interpreted in accordance with the convention that 100 bps = 1.0%.

(f) Section headings herein and in the other Loan Documents are included for convenience of reference only and shall not affect the interpretation of this Agreement or any other Loan Document.

Section 1.03 Accounting Terms.

(a) All accounting terms not specifically or completely defined herein shall be construed in conformity with, and all financial data (including financial ratios and other financial calculations) required to be submitted pursuant to this Agreement shall be prepared in conformity with, GAAP applied on a consistent basis, as in effect from time to time, applied in a manner consistent with that used in preparing the Audited Financial Statements, except as otherwise specifically prescribed herein. Notwithstanding anything herein to the contrary, determination of (i) the applicable pricing level under the definition of "Applicable Rate", (ii) compliance with any financial covenant or test hereunder and (iii) whether the conditions precedent to a Permitted Acquisition have been met shall be made on a Pro Forma Basis.

(b) If at any time any change in GAAP would affect the computation of any financial ratio or requirement set forth in any Loan Document, and either the Borrower or the Required Lenders shall so request, the Administrative Agent, the Lenders and the Borrower shall negotiate in good faith to amend such ratio or requirement to preserve the original intent thereof in light of such change in GAAP (subject to the approval of the Required Lenders); provided that, until so amended, (i) such ratio or requirement shall continue to be computed in accordance with GAAP prior to such change therein and (ii) the Borrower shall provide to the Administrative Agent and the Lenders financial statements and other documents required under this Agreement or as reasonably requested hereunder setting forth a reconciliation between calculations of such ratio or requirement made before and after giving effect to such change in GAAP.

Section 1.04 Rounding. Any financial ratios required to be maintained by the Borrower pursuant to this Agreement shall be calculated by dividing the appropriate component by the other component, carrying the result to one place more than the number of places by which such ratio is expressed herein and rounding the result up or down to the nearest number (with a rounding-up if there is no nearest number).

Section 1.05 References to Agreements and Laws. Unless otherwise expressly provided herein, (a) references to Organization Documents, agreements (including the Loan Documents) and other contractual instruments shall be deemed to include all subsequent amendments, restatements, extensions, supplements and other modifications thereto, but only to the extent that such amendments, restatements, extensions, supplements and other modifications are not prohibited by any Loan Document, and (b) references to any Law shall include all statutory and regulatory provisions consolidating, amending, replacing, supplementing or interpreting such Law.

Section 1.06 Times of Day. Unless otherwise specified, all references herein to times of day shall be references to Eastern time (daylight or standard, as applicable).

Section 1.07 Letter of Credit Amounts. Unless otherwise specified, all references herein to the amount of a Letter of Credit at any time shall be deemed to mean the maximum face amount of such Letter of Credit after giving effect to all increases thereof contemplated by such Letter of Credit or the Letter of Credit Application therefor, whether or not such maximum face amount is in effect at such time.

ARTICLE II
THE COMMITMENTS AND CREDIT EXTENSIONS

Section 2.01 Loans. Subject to the terms and conditions set forth herein, each Lender severally agrees to make loans (each such loan, a "Loan") to the Borrower from time to time, on any Business Day during the Availability Period, in an aggregate amount not to exceed at any time outstanding the amount of such Lender's Commitment; provided, however, that after giving effect to any Borrowing, (i) the Total Outstandings shall not exceed the Aggregate Commitments, and (ii) the aggregate Outstanding Amount of the Loans of any Lender, plus such Lender's Pro Rata Share of the Outstanding Amount of all L/C Obligations shall not exceed such Lender's Commitment. Within the limits of each Lender's Commitment, and subject to the other terms and conditions hereof, the Borrower may borrow under this Section 2.01, prepay under Section 2.05, and reborrow under this Section 2.01. Loans may be Base Rate Loans or Eurodollar Rate Loans, as further provided herein.

Section 2.02 Borrowings, Conversions and Continuations of Loans.

(a) Each Borrowing, each conversion of Loans from one Type to the other, and each continuation of Eurodollar Rate Loans shall be made upon the Borrower's irrevocable notice to the Administrative Agent, which may be given by telephone. Each such notice must be received by the Administrative Agent not later than 11:00 a.m. (i) three Business Days prior to the requested date of any Borrowing of, conversion to or continuation of Eurodollar Rate Loans or of any conversion of Eurodollar Rate Loans to Base Rate Loans, and (ii) on the requested date

of any Borrowing of Base Rate Loans. Each telephonic notice by the Borrower pursuant to this Section 2.02(a) must be confirmed promptly by delivery to the Administrative Agent of a written Loan Notice, appropriately completed and signed by a Responsible Officer of the Borrower. Each Borrowing of, conversion to, or continuation of, Eurodollar Rate Loans shall be in a principal amount of $5 million or a whole multiple of $500,000 in excess thereof. Except as provided in Sections 2.03(c), each Borrowing of or conversion to Base Rate Loans shall be in a principal amount of $500,000 or a whole multiple of $100,000 in excess thereof. Each Loan Notice (whether telephonic or written) shall specify (i) whether the Borrower is requesting a Borrowing, a conversion of Loans from one Type to the other, or a continuation of Eurodollar Rate Loans, (ii) the requested date of the Borrowing, conversion or continuation, as the case may be (which shall be a Business Day), (iii) the principal amount of Loans to be borrowed, converted or continued, (iv) the Type of Loans to be borrowed or to which existing Loans are to be converted, and (v) if applicable, the duration of the Interest Period with respect thereto. If the Borrower fails to specify a Type of Loan in a Loan Notice or if the Borrower fails to give a timely notice requesting a conversion or continuation, then the applicable Loans shall be made as, or converted to, Base Rate Loans. Any such automatic conversion of a Eurodollar Rate Loan to Base Rate Loans shall be effective as of the last day of the Interest Period then in effect with respect to the applicable Eurodollar Rate Loans. If the Borrower requests a Borrowing of, conversion to, or continuation of Eurodollar Rate Loans in any such Loan Notice, but fails to specify an Interest Period, it will be deemed to have specified an Interest Period of one month.

(b) Following receipt of a Loan Notice, the Administrative Agent shall promptly notify each Lender of the amount of its Pro Rata Share of the applicable Loans, and if no timely notice of a conversion or continuation is provided by the Borrower, the Administrative Agent shall notify each Lender of the details of any automatic conversion to Base Rate Loans described in the preceding subsection (a). In the case of a Borrowing, each Lender shall make the amount of its Loan available to the Administrative Agent in immediately available funds at the Administrative Agent's Office not later than 1:00 p.m. on the Business Day specified in the applicable Loan Notice. Upon satisfaction of the applicable conditions set forth in Section 4.02 (and, if such Borrowing is the initial Credit Extension, Section 4.01), the Administrative Agent shall make all funds so received available to the Borrower in like funds as received by the Administrative Agent either by (i) crediting the account of the Borrower on the books of Bank of America with the amount of such funds or (ii) wire transfer of such funds, in each case in accordance with instructions provided to (and reasonably acceptable to) the Administrative Agent by the Borrower; provided, however, that if, on the date the Loan Notice with respect to such Borrowing is given by the Borrower, there are L/C Borrowings outstanding, then the proceeds of such Borrowing shall be applied, first, to the payment in full of any such L/C Borrowings and second, to the Borrower as provided above.

(c) Except as otherwise provided herein, a Eurodollar Rate Loan may be continued or converted only on the last day of an Interest Period for such Eurodollar Rate Loan. During the existence of a Default, no Loans may be requested as, converted to or continued as Eurodollar Rate Loans without the consent of the Required Lenders.

(d) The Administrative Agent shall promptly notify the Borrower and the Lenders of the interest rate applicable to any Interest Period for Eurodollar Rate Loans upon

determination of such interest rate. The determination of the Eurodollar Rate by the Administrative Agent shall be conclusive in the absence of manifest error. At any time that Base Rate Loans are outstanding, the Administrative Agent shall notify the Borrower and the Lenders of any change in Bank of America's prime rate used in determining the Base Rate promptly following the public announcement of such change.

(e) After giving effect to all Borrowings, all conversions of Loans from one Type to the other, and all continuations of Loans as the same Type, there shall not be more than five Interest Periods in effect with respect to Loans.

(f) The failure of any Lender to make any Loan to be made by it as part of any Borrowing shall not relieve any other Lender of its obligation, if any, hereunder to make its Loan on the date of such Borrowing, but no Lender shall be responsible for the failure of any other Lender to make any Loan to be made by such other Lender on the date of any Borrowing.

Section 2.03 Letters of Credit.

(a) The Letter of Credit Commitment.

(i) Subject to the terms and conditions set forth herein, (A) the L/C Issuer agrees, in reliance upon the agreements of the other Lenders set forth in this Section 2.03, (1) from time to time on any Business Day during the period from the Closing Date until the Letter of Credit Expiration Date, to issue Letters of Credit for the account of the Borrower, and to amend Letters of Credit previously issued by it, in accordance with subsection (b) below, and (2) to honor drafts under the Letters of Credit, and (B) the Lenders severally agree to participate in Letters of Credit issued for the account of the Borrower; provided that the L/C Issuer shall not be obligated to make any L/C Credit Extension with respect to any Letter of Credit, and no Lender shall be obligated to participate in any Letter of Credit if, as of the date of such L/C Credit Extension, (x) the Total Outstandings would exceed the Aggregate Commitments, (y) the aggregate Outstanding Amount of the Loans of any Lender, plus such Lender's Pro Rata Share of the Outstanding Amount of all L/C Obligations, would exceed such Lender's Commitment, or (z) the Outstanding Amount of the L/C Obligations would exceed the Letter of Credit Sublimit. Within the foregoing limits, and subject to the terms and conditions hereof, the Borrower's ability to obtain Letters of Credit shall be fully revolving, and accordingly the Borrower may, during the foregoing period, obtain Letters of Credit to replace Letters of Credit that have expired or that have been drawn upon and reimbursed.

(ii) The L/C Issuer shall be under no obligation to issue any Letter of Credit if:

(A) any order, judgment or decree of any Governmental Authority or arbitrator shall by its terms purport to enjoin or restrain the L/C Issuer from issuing such Letter of Credit, or any Law applicable to the L/C Issuer or any request or directive (whether or not having the force of law) from any Governmental Authority with jurisdiction over the L/C Issuer shall prohibit, or

request that the L/C Issuer refrain from, the issuance of letters of credit generally or such Letter of Credit in particular or shall impose upon the L/C Issuer with respect to such Letter of Credit any restriction, reserve or capital requirement (for which the L/C Issuer is not otherwise compensated hereunder) not in effect on the Closing Date, or shall impose upon the L/C Issuer any unreimbursed loss, cost or expense which was not applicable on the Closing Date and which the L/C Issuer in good faith deems material to it;

(B) the expiry date of such requested Letter of Credit would occur more than twelve months after the date of issuance, unless the Required Lenders have approved such expiry date;

(C) the expiry date of such requested Letter of Credit would occur after the Letter of Credit Expiration Date, unless all the Lenders have approved such expiry date;

(D) the issuance of such Letter of Credit would violate one or more policies of the L/C Issuer; or

(E) such Letter of Credit is in an initial amount less than $100,000, in the case of a commercial Letter of Credit, or $500,000, in the case of a standby Letter of Credit.

(iii) The L/C Issuer shall be under no obligation to amend any Letter of Credit if (A) the L/C Issuer would have no obligation at such time to issue such Letter of Credit in its amended form under the terms hereof, or (B) the beneficiary of such Letter of Credit does not accept the proposed amendment to such Letter of Credit.

(b) Procedures for Issuance and Amendment of Letters of Credit.

(i) Each Letter of Credit shall be issued or amended, as the case may be, upon the request of the Borrower delivered to the L/C Issuer (with a copy to the Administrative Agent) in the form of a Letter of Credit Application, appropriately completed and signed by a Responsible Officer of the Borrower. Such Letter of Credit Application must be received by the L/C Issuer and the Administrative Agent not later than 11:00 a.m. at least two Business Days (or such later date and time as the L/C Issuer may agree in a particular instance in its sole discretion) prior to the proposed issuance date or date of amendment, as the case may be. In the case of a request for an initial issuance of a Letter of Credit, such Letter of Credit Application shall specify in form and detail satisfactory to the L/C Issuer the following: (A) the proposed issuance date of the requested Letter of Credit (which shall be a Business Day); (B) the amount thereof; (C) the expiry date thereof; (D) the name and address of the beneficiary thereof; (E) the documents to be presented by such beneficiary in case of any drawing thereunder; (F) the full text of any certificate to be presented by such beneficiary in case of any drawing thereunder; and (G) such other matters as the L/C Issuer may require. In the case of a request for an amendment of any outstanding Letter of Credit, such Letter of Credit Application shall specify in form and detail satisfactory to the L/C Issuer the following:

(A) the Letter of Credit to be amended; (B) the proposed date of amendment thereof (which shall be a Business Day); (C) the nature of the proposed amendment; and (D) such other matters as the L/C Issuer may require.

(ii) Promptly after receipt of any Letter of Credit Application, the L/C Issuer will confirm with the Administrative Agent (by telephone or in writing) that the Administrative Agent has received a copy of such Letter of Credit Application from the Borrower and, if not, the L/C Issuer will provide the Administrative Agent with a copy thereof. Upon receipt by the L/C Issuer of confirmation from the Administrative Agent that the requested issuance or amendment is permitted in accordance with the terms hereof, then, subject to the terms and conditions hereof, the L/C Issuer shall, on the requested date, issue a Letter of Credit for the account of the Borrower or enter into the applicable amendment, as the case may be, in each case in accordance with the L/C Issuer's usual and customary business practices. Immediately upon the issuance of each Letter of Credit, each Lender shall be deemed to, and hereby irrevocably and unconditionally agrees to, purchase from the L/C Issuer a risk participation in such Letter of Credit in an amount equal to the product of such Lender's Pro Rata Share times the amount of such Letter of Credit.

(iii) Promptly after its delivery of any Letter of Credit or any amendment to a Letter of Credit to an advising bank with respect thereto or to the beneficiary thereof, the L/C Issuer will also deliver to the Borrower and the Administrative Agent a true and complete copy of such Letter of Credit or amendment.

(c) Drawings and Reimbursements; Funding of Participations.

(i) Upon receipt from the beneficiary of any Letter of Credit of any notice of a drawing under such Letter of Credit, the L/C Issuer shall notify the Borrower and the Administrative Agent thereof and shall state the date payment shall be made by the L/C Issuer under a Letter of Credit (each such date, an "Honor Date"). Not later than 11:00 a.m. on the Honor Date, the Borrower shall reimburse the L/C Issuer through the Administrative Agent in an amount equal to the amount of such drawing. If the Borrower fails to so reimburse the L/C Issuer by such time, the Administrative Agent shall promptly notify each Lender of the Honor Date, the amount of the unreimbursed drawing (the "Unreimbursed Amount"), and the amount of such Lender's Pro Rata Share thereof. In such event, the Borrower shall be deemed to have requested a Borrowing of Base Rate Loans to be disbursed on the Honor Date in an amount equal to the Unreimbursed Amount, without regard to the minimum and multiples specified in Section 2.02 for the principal amount of Base Rate Loans, but subject to the amount of the unutilized portion of the Aggregate Commitments and the conditions set forth in Section 4.02 (other than the delivery of a Loan Notice). Any notice given by the L/C Issuer or the Administrative Agent pursuant to this Section 2.03(c)(i) may be given by telephone if immediately confirmed in writing; provided that the lack of such an immediate confirmation shall not affect the conclusiveness or binding effect of such notice.

(ii) Each Lender (including the Lender acting as L/C Issuer) shall upon any notice pursuant to Section 2.03(c)(i) make funds available to the Administrative

Agent for the account of the L/C Issuer at the Administrative Agent's Office in an amount equal to its Pro Rata Share of the Unreimbursed Amount not later than 1:00 p.m. on the Business Day specified in such notice by the Administrative Agent, whereupon, subject to the provisions of Section 2.03(c)(iii), each Lender that so makes funds available shall be deemed to have made a Base Rate Loan to the Borrower in such amount. The Administrative Agent shall remit the funds so received to the L/C Issuer.

(iii) With respect to any Unreimbursed Amount that is not fully refinanced by a Borrowing of Base Rate Loans because the conditions set forth in Section 4.02 cannot be satisfied or for any other reason, the Borrower shall be deemed to have incurred from the L/C Issuer an L/C Borrowing in the amount of the Unreimbursed Amount that is not so refinanced, which L/C Borrowing shall be due and payable on demand (together with interest) and shall bear interest at the Default Rate. In such event, each Lender's payment to the Administrative Agent for the account of the L/C Issuer pursuant to Section 2.03(c)(ii) shall be deemed payment in respect of its participation in such L/C Borrowing and shall constitute an L/C Advance from such Lender in satisfaction of its participation obligation under this Section 2.03.

(iv) Until each Lender funds its Loan or L/C Advance pursuant to this Section 2.03(c) to reimburse the L/C Issuer for any amount drawn under any Letter of Credit, interest in respect of such Lender's Pro Rata Share of such amount shall be solely for the account of the L/C Issuer.

(v) Each Lender's obligation to make Loans or L/C Advances to reimburse the L/C Issuer for amounts drawn under Letters of Credit, as contemplated by this Section 2.03(c), shall be absolute and unconditional and shall not be affected by any circumstance, including (A) any set-off, counterclaim, recoupment, defense or other right which such Lender may have against the L/C Issuer, the Administrative Agent, the Borrower or any other Person for any reason whatsoever, (B) the occurrence or continuance of a Default, or (C) any other occurrence, event or condition, whether or not similar to any of the foregoing; provided, however, that each Lender's obligation to make Loans pursuant to this Section 2.03(c) is subject to the conditions set forth in Section 4.02 (other than delivery by the Borrower of a Loan Notice). No such making of an L/C Advance shall relieve or otherwise impair the obligation of the Borrower to reimburse the L/C Issuer for the amount of any payment made by the L/C Issuer under any Letter of Credit, together with interest as provided herein.

(vi) If any Lender fails to make available to the Administrative Agent for the account of the L/C Issuer any amount required to be paid by such Lender pursuant to the foregoing provisions of this Section 2.03(c) by the time specified in Section 2.03(c)(ii), the L/C Issuer shall be entitled to recover from such Lender (acting through the Administrative Agent), on demand, such amount with interest thereon for the period from the date such payment is required to the date on which such payment is immediately available to the L/C Issuer at a rate per annum equal to the Federal Funds Rate from time to time in effect. A certificate of the L/C Issuer submitted to any Lender (through the Administrative Agent) with respect to any amounts owing under this clause (vi) shall be conclusive absent manifest error.

(d) Repayment of Participations.

(i) At any time after the L/C Issuer has made a payment under any Letter of Credit and has received from any Lender such Lender's L/C Advance in respect of such payment in accordance with Section 2.03(c), if the Administrative Agent receives for the account of the L/C Issuer any payment in respect of the related Unreimbursed Amount or interest thereon (whether directly from the Borrower or otherwise, including proceeds of Cash Collateral applied thereto by the Administrative Agent), the Administrative Agent will distribute to such Lender its Pro Rata Share thereof (appropriately adjusted, in the case of interest payments, to reflect the period of time during which such Lender's L/C Advance was outstanding) in the same funds as those received by the Administrative Agent.

(ii) If any payment received by the Administrative Agent for the account of the L/C Issuer pursuant to Section 2.03(c)(i) is required to be returned under any of the circumstances described in Section 10.06 (including pursuant to any settlement entered into by the L/C Issuer in its discretion), each Lender shall pay to the Administrative Agent for the account of the L/C Issuer its Pro Rata Share thereof on demand of the Administrative Agent, plus interest thereon from the date of such demand to the date such amount is returned by such Lender, at a rate per annum equal to the Federal Funds Rate from time to time in effect.

(e) Obligations Absolute. The obligation of the Borrower to reimburse the L/C Issuer for each drawing under each Letter of Credit and to repay each L/C Borrowing shall be absolute, unconditional and irrevocable, and shall be paid strictly in accordance with the terms of this Agreement under all circumstances, including the following:

(i) any lack of validity or enforceability of such Letter of Credit, this Agreement, or any other agreement or instrument relating thereto;

(ii) the existence of any claim, counterclaim, set-off, defense or other right that the Borrower may have at any time against any beneficiary or any transferee of such Letter of Credit (or any Person for whom any such beneficiary or any such transferee may be acting), the L/C Issuer or any other Person, whether in connection with this Agreement, the transactions contemplated hereby or by such Letter of Credit or any agreement or instrument relating thereto, or any unrelated transaction;

(iii) any draft, demand, certificate or other document presented under such Letter of Credit proving to be forged, fraudulent, invalid or insufficient in any respect or any statement therein being untrue or inaccurate in any respect; or any loss or delay in the transmission or otherwise of any document required in order to make a drawing under such Letter of Credit;

(iv) any payment by the L/C Issuer under such Letter of Credit against presentation of a draft or certificate that does not strictly comply with the terms of such Letter of Credit; or any payment made by the L/C Issuer under such Letter of Credit to any Person purporting to be a trustee in bankruptcy, debtor-in-possession, assignee for

the benefit of creditors, liquidator, receiver or other representative of or successor to any beneficiary or any transferee of such Letter of Credit, including any arising in connection with any proceeding under any Debtor Relief Law;

(v) any exchange, release or non-perfection of any collateral, or any release or amendment or waiver of or consent to the departure from any Guarantee, for all or any of the Obligations of the Borrower in respect of any Letter of Credit; or

(vi) any other circumstance or happening whatsoever, whether or not similar to any of the foregoing, including any other circumstance that might otherwise constitute a defense available to, or a discharge of, the Borrower.

The Borrower shall promptly examine a copy of each Letter of Credit and each amendment thereto that is delivered to it, and, in the event of any claim of noncompliance with the Borrower's instructions or other irregularity, the Borrower will immediately notify the L/C Issuer. The Borrower shall be conclusively deemed to have waived any such claim against the L/C Issuer and its correspondents unless such notice is given as aforesaid.

(f) Role of L/C Issuer. Each Lender and the Borrower agree that, in paying any drawing under a Letter of Credit, the L/C Issuer shall not have any responsibility to obtain any document (other than any sight draft, certificates and documents expressly required by the Letter of Credit) or to ascertain or inquire as to the validity or accuracy of any such document or the authority of the Person executing or delivering any such document. None of the L/C Issuer, any Agent-Related Person nor any of the respective correspondents, participants or assignees of the L/C Issuer shall be liable to any Lender for (i) any action taken or omitted in connection herewith at the request or with the approval of the Lenders or the Required Lenders, as applicable, (ii) any action taken or omitted in the absence of gross negligence or willful misconduct, or (iii) the due execution, effectiveness, validity or enforceability of any document or instrument related to any Letter of Credit or Letter of Credit Application. The Borrower hereby assumes all risks of the acts or omissions of any beneficiary or transferee with respect to its use of any Letter of Credit; provided, however, that this assumption is not intended to, and shall not, preclude the Borrower's pursuing such rights and remedies as it may have against the beneficiary or transferee at law or under any other agreement. None of the L/C Issuer, any Agent-Related Person, nor any of the respective correspondents, participants or assignees of the L/C Issuer, shall be liable or responsible for any of the matters described in clauses (i) through (vi) of Section 2.03(e); provided, however, that anything in such clauses to the contrary notwithstanding, the Borrower may have a claim against the L/C Issuer, and the L/C Issuer may be liable to the Borrower, to the extent, but only to the extent, of any direct, as opposed to consequential or exemplary, damages suffered by the Borrower which the Borrower proves were caused by the L/C Issuer's willful misconduct or gross negligence or the L/C Issuer's willful failure to pay under any Letter of Credit after the presentation to it by the beneficiary of a sight draft and certificate(s) strictly complying with the terms and conditions of a Letter of Credit. In furtherance and not in limitation of the foregoing, the L/C Issuer may accept documents that appear on their face to be in order, without responsibility for further investigation, regardless of any notice or information to the contrary, and the L/C Issuer shall not be responsible for the validity or sufficiency of any instrument transferring or assigning or purporting to transfer or

assign a Letter of Credit or the rights or benefits thereunder or proceeds thereof, in whole or in part, which may prove to be invalid or ineffective for any reason.

(g) Cash Collateral. Upon the request of the Administrative Agent, (i) if the L/C Issuer has honored any full or partial drawing request under any Letter of Credit and such drawing has resulted in an L/C Borrowing, or (ii) if, as of the Letter of Credit Expiration Date, any Letter of Credit may for any reason remain outstanding and partially or wholly undrawn, the Borrower shall immediately Cash Collateralize the then Outstanding Amount of all L/C Obligations (in an amount equal to such Outstanding Amount determined as of the date of such L/C Borrowing or the Letter of Credit Expiration Date, as the case may be). For purposes hereof, "Cash Collateralize" means to pledge and deposit with or deliver to the Administrative Agent, for the benefit of the L/C Issuer and the Lenders, as collateral for the L/C Obligations, cash or deposit account balances pursuant to documentation in form and substance satisfactory to the Administrative Agent and the L/C Issuer (which documents are hereby consented to by the Lenders). Derivatives of such term have corresponding meanings. The Borrower hereby grants to the Administrative Agent, for the benefit of the L/C Issuer and the Lenders, a security interest in all such cash, deposit accounts and all balances therein and all proceeds of the foregoing. Cash collateral shall be maintained in blocked, non-interest bearing deposit accounts at Bank of America. If at any time the Administrative Agent determines that any funds held as Cash Collateral are subject to any right or claim of any Person other than the Administrative Agent or that the total amount of such funds is less than the aggregate Outstanding Amount of L/C Obligations, the Borrower will forthwith, upon demand by the Administrative Agent, pay to the Administrative Agent, as additional funds to be deposited and held in deposit accounts at Bank of America as aforesaid, an amount equal to the excess of (i) such aggregate Outstanding Amount over (ii) the total amount of funds, if any, then held as Cash Collateral that the Administrative Agent determines to be free and clear of any such right and claim. Upon the drawing of any Letter of Credit for which funds are on deposit as Cash Collateral, such funds shall be applied, to the extent permitted under applicable Law, to reimburse the L/C Issuer.

(h) Applicability of ISP98 and UCP. Unless otherwise expressly agreed by the L/C Issuer and the Borrower when a Letter of Credit is issued, (i) the rules of the "International Standby Practices 1998" published by the Institute of International Banking Law & Practice (or such later version thereof as may be in effect at the time of issuance) shall apply to each standby Letter of Credit, and (ii) the rules of the Uniform Customs and Practice for Documentary Credits, as most recently published by the International Chamber of Commerce (the "ICC") at the time of issuance (including the ICC decision published by the Commission on Banking Technique and Practice on April 6, 1998 regarding the European single currency (euro)) shall apply to each commercial Letter of Credit.

(i) Letter of Credit Fees. The Borrower shall pay to the Administrative Agent for the account of each Lender in accordance with its Pro Rata Share a Letter of Credit fee for each issued Letter of Credit equal to the Applicable Rate times the daily maximum amount available to be drawn under such Letter of Credit (whether or not such maximum amount is then in effect under such issued Letter of Credit). Such letter of credit fees shall be computed on a quarterly basis in arrears. Such letter of credit fees shall be due and payable on the last Business Day of each March, June, September and December, commencing with the first such date to

occur after the issuance of such Letter of Credit, on the Letter of Credit Expiration Date and thereafter on demand. If there is any change in the Applicable Rate during any quarter, the daily maximum amount of each issued Letter of Credit shall be computed and multiplied by the Applicable Rate separately for each period during such quarter that such Applicable Rate was in effect.

(j) Fronting Fee and Documentary and Processing Charges Payable to L/C Issuer. The Borrower shall pay directly to the L/C Issuer for its own account a fronting fee with respect to each Letter of Credit in an amount equal to 0.125% per annum of the maximum available amount to be drawn under such Letter of Credit on the date of the issuance of such Letter of Credit payable on such date. In addition, the Borrower shall pay directly to the L/C Issuer for its own account the customary issuance, presentation, amendment and other processing fees, and other standard costs and charges, of the L/C Issuer relating to letters of credit as from time to time in effect. Such customary fees and standard costs and charges are due and payable on demand and are nonrefundable.

(k) Conflict with Letter of Credit Application. In the event of any conflict between the terms hereof and the terms of any Letter of Credit Application, the terms hereof shall control.

Section 2.04 [Intentionally Omitted].

Section 2.05 Prepayments.

(a) The Borrower may, upon notice to the Administrative Agent, at any time or from time to time voluntarily prepay Loans in whole or in part without premium or penalty; provided that (i) such notice must be received by the Administrative Agent not later than 11:00 a.m. (A) three Business Days prior to any date of prepayment of Eurodollar Rate Loans and (B) on the date of prepayment of Base Rate Loans, (ii) any prepayment of Eurodollar Rate Loans shall be in a principal amount of $5 million or a whole multiple of $500,000 in excess thereof, and (iii) any prepayment of Base Rate Loans shall be in a principal amount of $500,000 or a whole multiple of $100,000 in excess thereof or, in each case, if less, the entire principal amount thereof then outstanding. Each such notice shall specify the date and amount of such prepayment and the Type(s) of Loans to be prepaid. The Administrative Agent will promptly notify each Lender of its receipt of each such notice, and of the amount of such Lender's Pro Rata Share of such prepayment. If such notice is given by the Borrower, the Borrower shall make such prepayment and the payment amount specified in such notice shall be due and payable on the date specified therein. Any prepayment of a Eurodollar Rate Loan shall be accompanied by all accrued interest thereon, together with any additional amounts required pursuant to Section 3.05. Each such prepayment shall be applied to the Loans of the Lenders in accordance with their respective Pro Rata Shares.

(b) In the event the Successful IPO of the Borrower has not been consummated on or prior to the day which is 18 months after the Closing Date, the Borrower shall promptly prepay the Loans and/or Cash Collateralize or pay the L/C Obligations in an aggregate amount necessary to reduce the Outstanding Amount of Loans plus the Outstanding Amount of L/C Obligations to $50 million.

(c) In the event the Successful IPO of the Borrower has not been consummated on or prior to the which is day 30 months after the Closing Date, the Borrower shall promptly prepay the Loans and/or Cash Collateralize or pay the L/C Obligations in an aggregate amount necessary to reduce the Outstanding Amount of Loans plus the Outstanding Amount of L/C Obligations to $40 million.

(d) If for any reason the Total Outstandings at any time exceed the Aggregate Commitments then in effect, the Borrower shall immediately prepay Loans and/or Cash Collateralize the L/C Obligations in an aggregate amount equal to such excess; provided, however, that the Borrower shall not be required to Cash Collateralize the L/C Obligations pursuant to this Section 2.05(d) unless, after the prepayment in full of the Loans, the Total Outstandings exceed the Aggregate Commitments then in effect.

Section 2.06 Termination or Reduction of Commitments.

(a) The Borrower may, upon notice to the Administrative Agent, terminate the Aggregate Commitments, or from time to time permanently reduce the Aggregate Commitments; provided that (i) any such notice shall be received by the Administrative Agent not later than 11:00 a.m. five Business Days prior to the date of termination or reduction, (ii) any such partial reduction shall be in an aggregate amount of $2.5 million or any whole multiple of $500,000 in excess thereof, (iii) the Borrower shall not terminate or reduce the Aggregate Commitments if, after giving effect thereto and to any concurrent prepayments hereunder, the Total Outstandings would exceed the Aggregate Commitments, and (iv) if, after giving effect to any reduction of the Aggregate Commitments, the Letter of Credit Sublimit exceeds the amount of the Aggregate Commitments, such Letter of Credit Sublimit shall be automatically reduced by the amount of such excess. The Administrative Agent will promptly notify the Lenders of any such notice of termination or reduction of the Aggregate Commitments. Any reduction of the Aggregate Commitments shall be applied to the Commitment of each Lender according to its Pro Rata Share. All commitment fees accrued until the effective date of any termination of the Aggregate Commitments shall be paid on the effective date of such termination.

(b) On any date that any Loans are required to be prepaid and/or the L/C Obligations are required to be paid or Cash Collateralized as a result of a prepayment required by Sections 2.05 (b) or (c) (or would be so required if any Loans or L/C Obligations were outstanding), the Aggregate Commitments shall be automatically and permanently reduced by the total amount of such required prepayments and Cash Collateral; provided that, regardless of whether any Loans or L/C Obligations are outstanding, the Aggregate Commitments shall be automatically and permanently reduced in the amounts and under the conditions and times specified in Sections 2.05(b) and (c). The Administrative Agent will promptly notify the Lenders of any such reduction of the Aggregate Commitments. Any reduction of the Aggregate Commitments shall be applied to the Commitment of each Lender according to its Pro Rata Share.

Section 2.07 Repayment of Loans. The Borrower shall repay to the Lenders on the Maturity Date the Outstanding Amount of Loans on such date.

Section 2.08 Interest.

(a) Subject to the provisions of subsection (b) below, (i) each Eurodollar Rate Loan shall bear interest on the outstanding principal amount thereof for each Interest Period at a rate per annum equal to the Eurodollar Rate for such Interest Period plus the Applicable Rate; and (ii) each Base Rate Loan shall bear interest on the outstanding principal amount thereof from the applicable borrowing date at a rate per annum equal to the Base Rate plus the Applicable Rate.

(b) If any amount payable by the Borrower under any Loan Document is not paid when due (without regard to any applicable grace periods), whether at stated maturity, by acceleration or otherwise, such amount shall thereafter bear interest at a fluctuating interest rate per annum at all times equal to the Default Rate to the fullest extent permitted by applicable Law. Furthermore, while any Event of Default exists, the Borrower shall pay interest on the principal amount of all outstanding Obligations hereunder at the Default Rate to the fullest extent permitted by applicable Law. Accrued and unpaid interest on past due amounts (including interest on past due interest) shall be due and payable upon demand.

(c) Interest on each Loan shall be due and payable in arrears on each Interest Payment Date applicable thereto and at such other times as may be specified herein. Interest hereunder shall be due and payable in accordance with the terms hereof before and after judgment and before and after the commencement of any proceeding under any Debtor Relief Law.

Section 2.09 Fees. In addition to certain fees described in subsections (i) and (j) of Section 2.03:

(a) Commitment Fee. The Borrower shall pay to the Administrative Agent for the account of each Lender in accordance with its Pro Rata Share, a commitment fee equal to 0.75% per annum pre-Successful IPO or 0.50% per annum post-Successful IPO, as applicable, times the actual daily amount by which the Aggregate Commitments exceed the sum of (i) the Outstanding Amount of Loans and (ii) the Outstanding Amount of L/C Obligations. The commitment fee shall accrue at all times during the Availability Period, including at any time during which one or more of the conditions in Article IV is not met, and shall be due and payable quarterly in arrears on the last Business Day of each March, June, September and December, commencing with the first such date to occur after the Closing Date, and on the Maturity Date.

(b) Other Fees. The Borrower shall pay to the Co-Lead Arrangers and the Administrative Agent for their own respective accounts fees in the amounts and at the times specified in the Commitment Letter and the Fee Letter. Such fees shall be fully earned when paid and shall not be refundable for any reason whatsoever.

Section 2.10 Computation of Interest and Fees. All computations of interest for Base Rate Loans when the Base Rate is determined by Bank of America's "prime rate" shall be made on the basis of a year of 365 or 366 days, as the case may be, and actual days elapsed. All other computations of fees and interest shall be made on the basis of a 360-day year and actual days elapsed (which results in more fees or interest, as applicable, being paid than if computed on the

basis of a 365-day year). Interest shall accrue on each Loan for the day on which the Loan is made, and shall not accrue on a Loan, or any portion thereof, for the day on which the Loan or such portion is paid; provided that any Loan that is repaid on the same day on which it is made shall, subject to Section 2.12(a), bear interest for one day. Each determination by the Administrative Agent of an interest rate or fee hereunder shall be conclusive and binding for all purposes, absent manifest error.

Section 2.11 Evidence of Debt.

(a) The Credit Extensions made by each Lender shall be evidenced by one or more accounts or records maintained by such Lender and by the Administrative Agent in the ordinary course of business. The accounts or records maintained by the Administrative Agent and each Lender shall be conclusive absent manifest error of the amount of the Credit Extensions made by the Lenders to the Borrower and the interest and payments thereon. Any failure to so record or any error in doing so shall not, however, limit or otherwise affect the obligation of the Borrower hereunder to pay any amount owing with respect to the Obligations. In the event of any conflict between the accounts and records maintained by any Lender and the accounts and records of the Administrative Agent in respect of such matters, the accounts and records of the Administrative Agent shall control in the absence of manifest error. Upon the request of any Lender made through the Administrative Agent, the Borrower shall execute and deliver to such Lender (through the Administrative Agent) a Note, which shall evidence such Lender's Loans in addition to such accounts or records. Each Lender may attach schedules to its Note and endorse thereon the date, Type, amount and maturity of its Loans and payments with respect thereto.

(b) In addition to the accounts and records referred to in subsection (a) above, each Lender and the Administrative Agent shall maintain in accordance with its usual practice accounts or records evidencing the purchases and sales by such Lender of participations in Letters of Credit. In the event of any conflict between the accounts and records maintained by the Administrative Agent and the accounts and records of any Lender in respect of such matters, the accounts and records of the Administrative Agent shall control in the absence of manifest error.

(c) Entries made in good faith by the Administrative Agent in the Register pursuant to subsections (a) and (b) above, and by each Lender in its accounts pursuant to subsections (a) and (b) above, shall be prima facie evidence of the amount of principal and interest due and payable or to become due and payable from the Borrower to, in the case of the Register each Lender and, in the case of such account or accounts, such Lender, under this Agreement and the other Loan Documents, absent manifest error; provided that the failure of the Administrative Agent or such Lender to make any entry, or any finding that an entry is incorrect, in the Register or such account or accounts shall not limit or otherwise affect the obligations of the Borrower under this Agreement and the other Loan Documents.

Section 2.12 Payments Generally.

(a) All payments to be made by the Borrower shall be made without condition or deduction for any counterclaim, defense, recoupment or setoff. Except as otherwise expressly provided herein, all payments by the Borrower hereunder shall be made to the Administrative

Agent, for the account of the respective Lenders to which such payment is owed, at the Administrative Agent's Office in Dollars and in immediately available funds not later than 2:00 p.m. on the date specified herein. The Administrative Agent will promptly distribute to each Lender its Pro Rata Share (or other applicable share as provided herein) of such payment in like funds as received by wire transfer to such Lender's Lending Office. All payments received by the Administrative Agent after 2:00 p.m. shall be deemed received on the next succeeding Business Day and any applicable interest or fee shall continue to accrue.

(b) If any payment to be made by the Borrower shall become due on a day other than a Business Day, payment shall be made on the next following Business Day, and such extension of time shall be reflected in computing interest or fees, as the case may be; provided, however, that, if such extension would cause payment of interest on or principal of Eurodollar Rate Loans to be made in the next succeeding calendar month, such payment shall be made on the immediately preceding Business Day.

(c) Unless the Borrower or any Lender has notified the Administrative Agent, prior to the date any payment is required to be made by it to the Administrative Agent hereunder, that the Borrower or such Lender, as the case may be, will not make such payment, the Administrative Agent may assume that the Borrower or such Lender, as the case may be, has timely made such payment and may (but shall not be so required to), in reliance thereon, make available a corresponding amount to the Person entitled thereto. If and to the extent that such payment was not in fact made to the Administrative Agent in immediately available funds, then:

(i) if the Borrower failed to make such payment, each Lender shall forthwith on demand repay to the Administrative Agent the portion of such assumed payment that was made available to such Lender in immediately available funds, together with interest thereon in respect of each day from and including the date such amount was made available by the Administrative Agent to such Lender to the date such amount is repaid to the Administrative Agent in immediately available funds at the Federal Funds Rate from time to time in effect; and

(ii) if any Lender failed to make such payment, such Lender shall forthwith on demand pay to the Administrative Agent the amount thereof in immediately available funds, together with interest thereon for the period from the date such amount was made available by the Administrative Agent to the Borrower to the date such amount is recovered by the Administrative Agent (the "Compensation Period") at a rate per annum equal to the Federal Funds Rate from time to time in effect. If such Lender pays such amount to the Administrative Agent, then such amount shall constitute such Lender's Loan included in the applicable Borrowing. If such Lender does not pay such amount forthwith upon the Administrative Agent's demand therefor, the Administrative Agent may make a demand therefor upon the Borrower, and the Borrower shall pay such amount to the Administrative Agent, together with interest thereon for the Compensation Period at a rate per annum equal to the rate of interest applicable to the applicable Borrowing. Nothing herein shall be deemed to relieve any Lender from its obligation to fulfill its Commitment or to prejudice any rights which the Administrative Agent or the Borrower may have against any Lender as a result of any default by such Lender hereunder.

A notice of the Administrative Agent to any Lender or the Borrower with respect to any amount owing under this subsection (c) shall be conclusive, absent manifest error.

(d) If any Lender makes available to the Administrative Agent funds for any Loan to be made by such Lender as provided in the foregoing provisions of this Article II, and such funds are not made available to the Borrower by the Administrative Agent because the conditions to the applicable Credit Extension set forth in Article IV are not satisfied or waived in accordance with the terms hereof, the Administrative Agent shall return such funds (in like funds as received from such Lender) to such Lender, without interest.

(e) The obligations of the Lenders hereunder to make Loans and to fund participations in Letters of Credit are several and not joint. The failure of any Lender to make any Loan or to fund any such participation on any date required hereunder shall not relieve any other Lender of its corresponding obligation to do so on such date, and no Lender shall be responsible for the failure of any other Lender to so make its Loan or purchase its participation.

(f) Nothing herein shall be deemed to obligate any Lender to obtain the funds for any Loan in any particular place or manner or to constitute a representation by any Lender that it has obtained or will obtain the funds for any Loan in any particular place or manner.

(g) The Borrower hereby authorizes each Lender, if and to the extent payment owed to such Lender is not made when due hereunder, or in the case of a Lender under the Note held by such Lender, to charge from time to time against any and all of the Borrower's accounts with such Lender any amount so due.

Section 2.13 Sharing of Payments. If, other than as expressly provided elsewhere herein, any Lender shall obtain on account of the Loans made by it, or the participations in L/C Obligations held by it, any payment (whether voluntary, involuntary, through the exercise of any right of set-off, or otherwise) in excess of its ratable share (or other share contemplated hereunder) thereof, such Lender shall immediately (a) notify the Administrative Agent of such fact, and (b) purchase from the other Lenders such participations in the Loans made by them and/or such subparticipations in the participations in L/C Obligations held by them, as the case may be, as shall be necessary to cause such purchasing Lender to share the excess payment in respect of such Loans or such participations, as the case may be, pro rata with each of them; provided, however, that if all or any portion of such excess payment is thereafter recovered from the purchasing Lender under any of the circumstances described in Section 10.06 (including pursuant to any settlement entered into by the purchasing Lender in its discretion), such purchase shall to that extent be rescinded and each other Lender shall repay to the purchasing Lender the purchase price paid therefor, together with an amount equal to such paying Lender's ratable share (according to the proportion of (i) the amount of such paying Lender's required repayment to (ii) the total amount so recovered from the purchasing Lender) of any interest or other amount paid or payable by the purchasing Lender in respect of the total amount so recovered, without further interest thereon. The Borrower agrees that any Lender so purchasing a participation from another Lender may, to the fullest extent permitted by Law, exercise all its rights of payment (including the right of set-off, but subject to Section 10.09) with respect to such participation as fully as if such Lender were the direct creditor of the Borrower in the amount of such participation. The Administrative Agent will keep records (which shall be conclusive and

binding in the absence of manifest error) of participations purchased under this Section and will in each case notify the Lenders following any such purchases or repayments. Each Lender that purchases a participation pursuant to this Section shall from and after such purchase have the right to give all notices, requests, demands, directions and other communications under this Agreement with respect to the portion of the Obligations purchased to the same extent as though the purchasing Lender were the original owner of the Obligations purchased.

ARTICLE III
TAXES, YIELD PROTECTION AND ILLEGALITY

Section 3.01 Taxes.

(a) Subject to Section 10.15, any and all payments by the Borrower to or for the account of the Administrative Agent or any Lender under any Loan Document shall be made free and clear of and without deduction for any and all present or future taxes, duties, levies, imposts, deductions, assessments, fees, withholdings or similar charges and all liabilities with respect thereto, excluding, in the case of the Administrative Agent and each Lender, taxes imposed on or measured by its overall net income and franchise taxes imposed on it (in lieu of net income taxes), by the jurisdiction (or any political subdivision thereof) under the Laws of which the Administrative Agent or such Lender, as the case may be, is organized or maintains a lending office (all such non-excluded taxes, duties, levies, imposts, deductions, assessments, fees, withholdings or similar charges, and liabilities being hereinafter referred to as "Taxes"). Subject to Section 10.15, if the Borrower shall be required by any Laws to deduct any Taxes from or in respect of any sum payable under any Loan Document to the Administrative Agent or any Lender, (i) the sum payable shall be increased as necessary so that after making all required deductions (including deductions applicable to additional sums payable under this Section), each of the Administrative Agent and such Lender receives an amount equal to the sum it would have received had no such deductions been made, (ii) the Borrower shall make such deductions, (iii) the Borrower shall pay the full amount deducted to the relevant taxation authority or other authority in accordance with applicable Law, and (iv) within 30 days after the date of such payment, the Borrower shall furnish to the Administrative Agent (which shall forward the same to such Lender) the original or a certified copy of a receipt evidencing payment thereof.

(b) In addition, the Borrower agrees to pay any and all present or future stamp, court or documentary taxes and any other excise or property taxes or charges or similar levies which arise from any payment made under any Loan Document or from the execution, delivery, performance, enforcement or registration of, or otherwise with respect to, any Loan Document (hereinafter referred to as "Other Taxes").

(c) If the Borrower shall be required to deduct or pay any Taxes or Other Taxes from or in respect of any sum payable under any Loan Document to the Administrative Agent or any Lender, the Borrower shall also pay to the Administrative Agent or to such Lender, as the case may be, at the time interest is paid, such additional amount that the Administrative Agent or such Lender specifies is necessary to preserve the after-tax yield (after factoring in all taxes, including taxes imposed on or measured by net income) that the Administrative Agent or such Lender would have received if such Taxes or Other Taxes had not been imposed.

(d) The Borrower agrees to indemnify the Administrative Agent and each Lender for (i) the full amount of Taxes and Other Taxes (including any Taxes or Other Taxes imposed or asserted by any jurisdiction on amounts payable under this Section) paid by the Administrative Agent and such Lender, (ii) amounts payable under this Section 3.01 and (iii) any liability (including additions to tax, penalties, interest and expenses) arising therefrom or with respect thereto, in each case whether or not such Taxes or Other Taxes were correctly or legally imposed or asserted by the relevant Governmental Authority. Payment under this subsection (d) shall be made within 30 days after the date the Lender or the Administrative Agent makes a demand therefor.

Section 3.02 Illegality. If any Lender determines that any Law has made it unlawful, or that any Governmental Authority has asserted that it is unlawful, for any Lender or its applicable Lending Office to make, maintain or fund Eurodollar Rate Loans, or to determine or charge interest rates based upon the Eurodollar Rate, then, on notice thereof by such Lender to the Borrower through the Administrative Agent, any obligation of such Lender to make or continue Eurodollar Rate Loans or to convert Base Rate Loans to Eurodollar Rate Loans shall be suspended until such Lender notifies the Administrative Agent and the Borrower that the circumstances giving rise to such determination no longer exist. Upon receipt of such notice, and upon demand from such Lender (with a copy to the Administrative Agent), the Borrower shall, at its sole option so long as no Default has occurred, prepay or, if applicable, convert all Eurodollar Rate Loans of such Lender to Base Rate Loans, either on the last day of the Interest Period therefor, if such Lender may lawfully continue to maintain such Eurodollar Rate Loans to such day, or immediately, if such Lender may not lawfully continue to maintain such Eurodollar Rate Loans. Upon any such prepayment or conversion, the Borrower shall also pay accrued interest on the amount so prepaid or converted. Each Lender agrees to designate a different Lending Office if such designation will avoid the need for such notice and will not, in the good faith judgment of such Lender, otherwise be materially disadvantageous to such Lender.

Section 3.03 Inability to Determine Rates. If the Required Lenders determine that for any reason adequate and reasonable means do not exist for determining the Eurodollar Rate for any requested Interest Period with respect to a proposed Eurodollar Rate Loan, or that the Eurodollar Rate for any requested Interest Period with respect to a proposed Eurodollar Rate Loan does not adequately and fairly reflect the cost to such Lenders of funding such Loan, the Administrative Agent will promptly so notify the Borrower and each Lender. Thereafter, the obligation of the Lenders to make or maintain Eurodollar Rate Loans shall be suspended until the Administrative Agent (upon the instruction of the Required Lenders) revokes such notice. Upon receipt of such notice, the Borrower may revoke any pending request for a Borrowing of, conversion to or continuation of Eurodollar Rate Loans or, failing that, will be deemed to have converted such request into a request for a Borrowing of Base Rate Loans in the amount specified therein.

Section 3.04 Increased Cost and Reduced Return; Capital Adequacy; Reserves on Eurodollar Rate Loans.

(a) If any Lender determines that as a result of the introduction of or any change in or in the interpretation of any Law, or such Lender's compliance therewith, there shall be any increase in the cost to such Lender of agreeing to make or making, funding or maintaining

Eurodollar Rate Loans or (as the case may be) issuing or participating in Letters of Credit, or a reduction in the amount received or receivable by such Lender in connection with any of the foregoing (excluding for purposes of this subsection (a) any such increased costs or reduction in amount resulting from (i) Taxes or Other Taxes (as to which Section 3.01 shall govern), (ii) changes in the basis of taxation of overall net income or overall gross income by the United States or any foreign jurisdiction or any political subdivision of either thereof under the Laws of which such Lender is organized or has its Lending Office, and (iii) reserve requirements contemplated by Section 3.04(c)), then from time to time upon demand of such Lender (with a copy of such demand to the Administrative Agent), the Borrower shall pay to such Lender such additional amounts as will compensate such Lender for such increased cost or reduction.

(b) If any Lender determines that the introduction of any Law regarding capital adequacy or any change therein or in the interpretation thereof, or compliance by such Lender (or its Lending Office) therewith, has the effect of reducing the rate of return on the capital of such Lender or any corporation controlling such Lender as a consequence of such Lender's obligations hereunder (taking into consideration its policies with respect to capital adequacy and such Lender's desired return on capital), then from time to time upon demand of such Lender (with a copy of such demand to the Administrative Agent), the Borrower shall pay to such Lender such additional amounts as will compensate such Lender for such reduction; provided in no event shall the amount set forth in such demand cover a period commencing earlier than 180 days prior to the date of the demand.

(c) The Borrower shall pay to each Lender, as long as such Lender shall be required to maintain reserves with respect to liabilities or assets consisting of or including Eurocurrency funds or deposits (currently known as "Eurocurrency liabilities"), additional interest on the unpaid principal amount of each Eurodollar Rate Loan equal to the actual costs of such reserves allocated to such Loan by such Lender (as determined by such Lender in good faith, which determination shall be conclusive), which shall be due and payable on each date on which interest is payable on such Loan; provided the Borrower shall have received at least 15 days' prior notice (with a copy to the Administrative Agent) of such additional interest from such Lender. If a Lender fails to give notice 15 days prior to the relevant Interest Payment Date, such additional interest shall be due and payable 15 days from receipt of such notice.

Section 3.05 Funding Losses. Upon demand of any Lender (with a copy to the Administrative Agent) from time to time, the Borrower shall promptly compensate such Lender for and hold such Lender harmless from any loss, cost or expense incurred by it as a result of:

(a) any continuation, conversion, payment or prepayment of any Loan other than a Base Rate Loan on a day other than the last day of the Interest Period for such Loan (whether voluntary, mandatory, automatic, by reason of acceleration, or otherwise); or

(b) any failure by the Borrower (for a reason other than the failure of such Lender to make a Loan) to prepay, borrow, continue or convert any Loan other than a Base Rate Loan on the date or in the amount notified by the Borrower;

including any loss or expense arising from the liquidation or reemployment of funds obtained by it to maintain such Loan or from fees payable to terminate the deposits from which such funds

were obtained. The Borrower shall also pay any customary administrative fees charged by such Lender in connection with the foregoing.

For purposes of calculating amounts payable by the Borrower to the Lenders under this Section 3.05, each Lender shall be deemed to have funded each Eurodollar Rate Loan made by it at the Eurodollar Rate for such Loan by a matching deposit or other borrowing in the London interbank eurodollar market for a comparable amount and for a comparable period, whether or not such Eurodollar Rate Loan was in fact so funded.

Section 3.06 Matters Applicable to all Requests for Compensation.

(a) A certificate of the Administrative Agent or any Lender claiming compensation under this Article III and setting forth the additional amount or amounts to be paid to it hereunder shall be conclusive in the absence of manifest error. In determining such amount, the Administrative Agent or such Lender may use any reasonable averaging and attribution methods.

(b) Upon a Lender's making a claim for compensation under Sections 3.01 or 3.04, the Borrower may replace such Lender in accordance with Section 10.19.

Section 3.07 Survival. All of the Borrower's obligations under this Article III shall survive termination of the Aggregate Commitments and repayment of all other Obligations hereunder.

ARTICLE IV
CONDITIONS PRECEDENT TO CREDIT EXTENSIONS

Section 4.01 Conditions of Initial Credit Extension. The obligation of each Lender to make its initial Credit Extension hereunder is subject to satisfaction of the following conditions precedent:

(a) The Administrative Agent's receipt of the following, each of which shall be originals or facsimiles (followed promptly by originals) unless otherwise specified, each properly executed by a duly authorized officer of the signing Loan Party, each dated the Closing Date (or, in the case of certificates of governmental officials, a recent date before the Closing Date) and each in form and substance satisfactory to the Administrative Agent and its legal counsel:

(i) executed counterparts of this Agreement, each Collateral Document and the Subsidiary Guaranty, sufficient in number for distribution to the Administrative Agent, each Lender and the Borrower;

(ii) an original Note executed by the Borrower in favor of each Lender requesting a Note;

(iii) such certificates of resolutions or other action, incumbency certificates evidencing the identity, authority and capacity of each duly authorized officer authorized to act on behalf of such Loan Party in connection with this Agreement and the other Loan Documents to which such Loan Party is a party;

(iv) such documents and certifications as the Administrative Agent may reasonably require to evidence each of the Borrower and each of the Subsidiaries is duly organized or formed, and each of the Borrower and each of the Subsidiaries is validly existing, in good standing and qualified to engage in business in each jurisdiction where its ownership, lease or operation of properties or the conduct of its business requires such qualification, except to the extent that failure to do so could not reasonably be expected to have a Material Adverse Effect, including, certified copies of the Organization Documents of the Borrower and each of the Subsidiaries, certificates of good standing and/or qualification to engage in business and tax clearance certificates;

(v) favorable opinions of counsel for the Loan Parties, addressed to the Administrative Agent and each Lender, as to the matters set forth in Exhibit F, with such customary assumptions, qualifications and exceptions;

(vi) a certificate of a duly authorized officer of each Loan Party and any Subsidiary whose capital stock is subject to a pledge under the Pledge Agreement either (A) attaching copies of all consents, licenses and approvals required in connection with the execution, delivery and performance by such Loan Party and the validity against such Loan Party of the Loan Documents to which it is a party and, required in connection with the Loan Documents and the transactions contemplated thereby (including, without limitation, the pledge of any Subsidiary's capital stock and the expiration, without imposition of conditions, of all applicable waiting periods in connection with the transactions contemplated by the Loan Documents), and such consents, licenses and approvals shall be in full force and effect, or (B) stating that no such consents, licenses or approvals are so required;

(vii) a certificate signed by a duly authorized officer of the Borrower certifying (A) that the conditions specified in Sections 4.02(a) and (b) have been satisfied, and (B) that there has been no event or circumstance since the date of the most recent Audited Financial Statements that has had or could be reasonably expected to have, either individually or in the aggregate, a Material Adverse Effect;

(viii) evidence that all insurance required to be maintained pursuant to the Loan Documents has been obtained and is in full force and effect;

(ix) original certificates evidencing all of the issued and outstanding shares of capital stock or other equity or other ownership interests required to be pledged pursuant to the terms of the Pledge Agreement (including without limitation pledges of all the capital stock of the Guarantors, Molina Healthcare of Washington and Molina Healthcare of Utah), which certificates shall be accompanied by undated stock powers duly executed in blank by each relevant pledgor in favor of the Administrative Agent;

(x) the original Intercompany Notes required to be pledged pursuant to the terms of the Pledge Agreement, duly endorsed in blank by each relevant pledgor in favor of the Administrative Agent;

(xi) certified copies of Uniform Commercial Code Requests for Information or Copies (Form UCC-11) or similar search reports certified by a party acceptable to the Administrative Agent, dated a date reasonably near (but prior to) the Closing Date, listing all effective UCC financing statements, tax liens and judgment liens which name the Borrower or any of the Subsidiaries, as the debtor, and which are filed in the jurisdictions in which the Borrower and the Subsidiaries are organized or have any property or assets, and in such other jurisdictions as the Administrative Agent may reasonably request, together with copies of such financing statements (none of which (other than financing statements filed pursuant to the terms hereof in favor of the Administrative Agent, if such Form UCC-11 or search report, as the case may be, is current enough to list such financing statements) shall cover any of the Collateral, other than Liens existing on the date hereof and listed on Schedule 7.01);

(xii) with respect to all the Intellectual Property Collateral, search results from the United States Patent and Trademark Office and United States Copyright Office to the extent any patents, trademarks or copyrights form a part of the Collateral;

(xiii) (A) acknowledgment copies of UCC financing statements naming the Borrower and each Eligible Subsidiary as the debtor and the Administrative Agent as the secured party, which such UCC financing statements have been filed under the UCC of all jurisdictions as may be necessary or, in the opinion of the Administrative Agent, desirable to perfect the first priority security interest of the Administrative Agent pursuant to the Security Agreement; (B) evidence reasonably satisfactory to the Administrative Agent of the filing (or delivery for filing) of appropriate trademark, copyright and patent security supplements with the United States Patent and Trademark Office and United States Copyright Office to the extent relevant; and (C) such control agreements (including the Account Control Agreements) as reasonably requested by the Administrative Agent with respect to the Collateral under the Security Agreement in which a security interest may be perfected by "control" (as defined in the relevant UCC), in each case, duly executed and delivered or authenticated by the parties thereto;

(xiv) evidence that all other action that the Administrative Agent may deem necessary or desirable in order to perfect and protect the first priority liens and security interests (together with access letters) created under the Collateral Documents has been taken (including, without limitation, receipt of duly executed payoff letters, UCC-3 termination statements and landlords' and bailees' waiver and consent agreements);

(xv) a certificate signed by a duly authorized officer of the Borrower attaching true and correct copies of all Material Contracts of each Loan Party and their respective Subsidiaries;

(xvi) such other assurances, certificates, documents, consents and waivers, estoppel certificates, or opinions as the Administrative Agent, the L/C Issuer or the Required Lenders reasonably may require; and

(xvii) evidence of appointment of CT Corporation System as agent for service of process in accordance with Section 10.17 for the Borrower and in accordance with Section 5.16(b) of the Guaranty Agreement for the Guarantor.

(b) The Lenders shall be satisfied that, concurrently with the Closing Date, all existing Indebtedness of the Loan Parties and their respective Subsidiaries has been repaid, redeemed or defeased in full or otherwise satisfied and extinguished, except the Indebtedness listed on Schedule 7.03 hereof, which Indebtedness shall be on terms and conditions satisfactory to the Lenders and all Liens securing such obligations have been or concurrently with the Closing Date are being released, other than Liens listed on Schedule 7.01.

(c) The Lenders shall be satisfied with the amount, terms and conditions of all intercompany Indebtedness.

(d) The fees and expenses of the Loan Parties pursuant to the Commitment Letter, Fee Letter and Section 10.04 required to be paid on or before the Closing Date shall have been paid.

(e) The Borrower shall have paid all Attorney Costs of the Administrative Agent to the extent invoiced prior to or on the Closing Date, plus such additional amounts of Attorney Costs as shall constitute its reasonable estimate of Attorney Costs incurred or to be incurred by it through the closing proceedings (provided, that such estimate shall not thereafter preclude a final settling of accounts between the Borrower and the Administrative Agent).

Section 4.02 Conditions to all Credit Extensions. The obligation of each Lender to honor any Request for Credit Extension (other than a Loan Notice requesting only a conversion of Loans to the other Type, or a continuation of Eurodollar Rate Loans) is subject to the following conditions precedent:

(a) The representations and warranties of the Borrower contained in Article V or any other Loan Document, or which are contained in any document furnished at any time under or in connection herewith or therewith, shall be true and correct in all material respects on and as of the date of such Credit Extension, except to the extent that such representations and warranties specifically refer to an earlier date, in which case they shall be true and correct in all material respects as of such earlier date, and except that for purposes of this Section 4.02, the representations and warranties contained in subsections (a) and (b) of Section 5.05 shall be deemed to refer to the most recent statements furnished pursuant to subsections (a) and (b), respectively, of Section 6.01 and the references to Schedules shall be deemed to refer to the most updated supplements to the Schedules furnished pursuant to subsection (b) of Section 6.02.

(b) No Default shall exist, or would result from such proposed Credit Extension.

(c) The Administrative Agent and, if applicable, the L/C Issuer shall have received a Request for Credit Extension in accordance with the requirements hereof.

(d) The Administrative Agent shall have received such other approvals, opinions or documents as any Lender, through the Administrative Agent, may reasonably request.

Each Request for Credit Extension (other than a Loan Notice requesting only a conversion of Loans to the other Type or a continuation of Eurodollar Rate Loans) submitted by the Borrower shall be deemed to be a representation and warranty that the conditions specified in Sections 4.02(a) and (b) have been satisfied on and as of the date of the applicable Credit Extension.

ARTICLE V
REPRESENTATIONS AND WARRANTIES

The Borrower represents and warrants to the Administrative Agent and the Lenders that:

Section 5.01 Existence, Qualification and Power. The Borrower and each of the Subsidiaries (a) is duly organized or formed, validly existing and in good standing under the Laws of the jurisdiction of its incorporation or organization, (b) has all requisite corporate power and authority to (i) own its assets and carry on its business and (ii) execute, deliver and perform its obligations under the Loan Documents to which it is a party, including, without limitation, to conduct its business or to own, as applicable, an HMO in the state of its organization, and (c) is duly qualified and is licensed and in good standing under the Laws of each jurisdiction where its ownership, lease or operation of its properties or the conduct of its business requires such qualification or license, except where such failure could not reasonably be expected to have a Material Adverse Effect.

Section 5.02 Authorization; No Contravention. The execution, delivery and performance by each Loan Party of each Loan Document to which such Person is party, have been duly authorized by all necessary corporate or other organizational action. The execution, delivery and performance by each Loan Party of each Loan Document to which it is a party, and the consummation of the transactions contemplated hereby with respect to each Loan Party and any of their respective Subsidiaries, do not and will not: (a) contravene the terms of any of such Person's Organization Documents; (b) conflict with or result in any breach or contravention of, or (except for the Liens created under the Loan Documents) the creation of any Lien under, (i) any material Contractual Obligation to which such Person is a party or (ii) any order, injunction, writ or decree of any Governmental Authority or any arbitral award to which such Person or its property is subject; or (c) violate any material Law applicable to any Loan Party, including, without limitation, state and Federal Laws relating to health care organizations and health care providers.

Section 5.03 Governmental Authorization; Other Consents. Except as specifically disclosed on Schedule 5.03, no material approval, consent, exemption, authorization, or other action by, or notice to, or filing with, any Governmental Authority or any other Person is necessary or required in connection with (a) the execution, delivery or performance by, or

enforcement against, any Loan Party of this Agreement or any other Loan Document (other than those that have been obtained), (b) the validity or enforceability of any Loan Documents against the Loan Parties (except such filings as are necessary in connection with the perfection of the Liens created by such Loan Documents), or (c) the consummation of the transactions contemplated hereby (other than those that have been obtained by the Borrower and the Subsidiaries).

Section 5.04 Binding Effect. This Agreement has been, and each other Loan Document, when delivered hereunder, will have been, duly executed and delivered by each Loan Party that is party thereto. This Agreement constitutes, and each other Loan Document when so delivered will constitute, a legal, valid and binding obligation of such Loan Party, enforceable against each Loan Party that is party thereto in accordance with its terms, except as enforceability may be limited by Debtor Relief Laws.

Section 5.05 Financial Statements; No Material Adverse Effect.

(a) The Audited Financial Statements (i) were prepared in accordance with GAAP consistently applied throughout the period covered thereby, except as otherwise expressly noted therein, (ii) fairly present the financial condition of the Borrower and the Subsidiaries as of the date thereof and their results of operations for the period covered thereby in accordance with GAAP (or as applicable, with respect to HMO Subsidiaries, SAP) consistently applied throughout the period covered thereby, except as otherwise expressly noted therein, and (iii) show all material indebtedness and other material liabilities, direct or contingent, of the Borrower and the Subsidiaries as of the date thereof, including material liabilities for taxes, material commitments and Indebtedness.

(b) Since the date of the most recent Audited Financial Statements, there has been no event or circumstance, either individually or in the aggregate, that has had or could reasonably be expected to have a Material Adverse Effect.

(c) The financial statements delivered to the Administrative Agent and each Lender pursuant to Sections 6.01(a) and (b) (i) will be prepared in accordance with GAAP (or, as applicable, with respect to HMO Subsidiaries, SAP), except as otherwise noted therein, and (ii) will fairly present the financial condition of the Borrower and the Subsidiaries as of the date thereof and their results of operations for the period covered thereby in accordance with GAAP (or, as applicable, with respect to HMO Subsidiaries, SAP).

Section 5.06 Litigation. There are no actions, suits, proceedings, claims or disputes pending or, to the actual knowledge of the Borrower, threatened or contemplated, at law, in equity, in arbitration or before any Governmental Authority, by or against the Borrower or any of the Subsidiaries or against any of their respective properties or revenues or injunctions, writs, temporary restraining orders or other orders of any nature issued by any court or Governmental Authority that (a) purport to affect, pertain to or enjoin or restrain the execution, delivery or performance of this Agreement or any other Loan Document, or any of the transactions contemplated hereby, or (b) either individually or in the aggregate, if determined adversely, could reasonably be expected to have a Material Adverse Effect.

Section 5.07 No Default. No default exists and, to the knowledge of the Borrower, no default has been asserted under or with respect to any Contractual Obligation that could, either individually or in the aggregate, reasonably be expected to have a Material Adverse Effect. No Default could reasonably be expected to result from the consummation of the transactions contemplated by this Agreement or any other Loan Document.

Section 5.08 Subsidiaries. The Borrower has no Subsidiaries other than those specifically disclosed in Part (a) of Schedule 5.08 (including the jurisdiction of organization, classes of capital stock (including options, warrants, rights of subscription, conversion and exchangeability and other similar rights, ownership and ownership percentages thereof) and whether such Subsidiaries are capitalized or licensed as an HMO, conducting HMO Business and/or providing managed care services) and has no equity investments in any other corporation or entity other than those specifically disclosed in Part (b) of Schedule 5.08 or on Schedule 7.02. The outstanding shares of capital stock shown have been validly issued, fully-paid and are non-assessable and owned free and clear of Liens. The outstanding shares of capital stock shown are not subject to buy-sell, voting trust or other shareholder agreement, except as specifically disclosed in Part (c) of Schedule 5.08.

Section 5.09 Ownership of Personal Property; Liens. Each of the Borrower and each Subsidiary has good title to all of their respective material personal properties and assets (except for those properties and assets disposed of not in violation of this Agreement and the other Loan Documents and except for encumbrances and title defects that could not be reasonably be expected to have a Material Adverse Effect). The property and assets of the Borrower and the Subsidiaries are subject to no Liens, other than Liens permitted by Section 7.01. Each of the Borrower and each of the Subsidiaries has obtained all material licenses, permits, franchises or other certifications, consents, approvals and authorizations, governmental or private, necessary to the ownership of its property and assets and the conduct of its business.

Section 5.10 Intellectual Property; Licenses, Etc. The Borrower and the Subsidiaries own, or possess the right to use, all of the trademarks, service marks, trade names, copyrights, patents, patent rights, franchises, licenses and other intellectual property rights (collectively, "IP Rights") that are reasonably necessary for the operation of its businesses. To the actual knowledge of the Borrower the use of such IP Rights by the Borrower and its Subsidiaries does not infringe on the rights of any Person, except for such infringements that could not reasonably be expected to have a Material Adverse Effect. To the best knowledge of the Borrower, no slogan or other advertising device, product, process, method, substance, part or other material now employed, or now contemplated to be employed, by the Borrower or any Subsidiary infringes upon any rights held by any other Person.

Section 5.11 Real Estate, Lease. (a) Schedule 5.11 sets forth an accurate description, as of the Closing Date, of the location, by state and street address, of all Real Property Assets owned by the Borrower and the Subsidiaries under the heading "Fee Properties" and all Real Property Assets leased by the Borrower and the Subsidiaries under the heading "Leased Properties", together with, in the case of owned Real Property Assets, a statement as to whether each such Real Property Asset is the subject of a contract of sale (and, if so, a statement as to the status of such sale), and, in the case of the each Real Property Asset, the identity of the lessor and lessee, the term of the lease and the annual rental payments.

(b) The Borrower and each of the Subsidiaries has (i) good and marketable fee title to all of its owned Real Property Assets and (ii) good and valid title to the leasehold estates in all of the leased Real Property Assets, in each case free and clear of all Liens, except Permitted Liens.

(c) All material permits, licenses, franchises or other certifications, consents, approvals and authorizations, governmental or private with respect to the Real Property Assets, necessary to enable the Borrower and any of the Subsidiaries to lawfully occupy and use such property for all of the purposes for which it is currently occupied and used have been lawfully issued and are in full force and effect, other than such permits, licenses, franchises or other certifications, consents, approvals and authorizations, governmental or private, which, if not obtained, would not have a material adverse effect on the intended use or operation of any such Real Property Assets. All the Real Property Assets are in compliance in all material respects with all applicable legal requirements, including the Americans with Disabilities Act of 1990. Except as specifically disclosed in Schedule 5.11, no consent or approval of any landlord or other third party in connection with any leased Property Assets is necessary for any Loan Party to enter into and execute the Loan Documents.

(d) All material easements, cross easements, licenses, air rights and rights-of way or other similar property interests, if any, necessary for the full utilization of the Improvements for their intended purposes have been obtained and are in full force and effect.

Section 5.12 Environmental Matters. Except as would not reasonably be expected to have a Material Adverse Effect, to the knowledge of the Borrower:

(a) Each of the facilities and properties owned, leased or operated by the Borrower and the Subsidiaries (the "Subject Properties") and all operations at the Subject Properties are in compliance with all applicable Environmental Laws, and there is no violation of any Environmental Law with respect to the Subject Properties or the businesses operated by the Borrower and the Subsidiaries (the "Businesses"), and there are no conditions relating to the Businesses or Subject Properties that could be reasonably likely to give rise to liability under any applicable Environmental Laws.

(b) None of the Subject Properties contains, or to the actual knowledge of the Borrower, has previously contained, any Hazardous Materials at, on or under the Subject Properties in amounts or concentrations that constitute or constituted a violation of, or could give rise to liability under, Environmental Laws.

(c) Neither the Borrower nor any of the Subsidiaries has received any written or verbal notice of, or inquiry from any Governmental Authority regarding, any violation, alleged violation, non-compliance, liability or potential liability regarding environmental matters or compliance with Environmental Laws with regard to any of the Subject Properties or the Businesses, nor does the Borrower have knowledge that any such notice will be received or is being threatened.

(d) Hazardous Materials have not been transported or disposed of from the Subject Properties, or generated, treated, stored or disposed of at, on or under any of the Subject

Properties or any other location, in each case by or on behalf of the Borrower or any of the Subsidiaries in violation of, or in a manner that would be reasonably likely to give rise to liability under, any applicable Environmental Law.

(e) There are no consent decrees or other decrees, consent orders, administrative orders or other orders, or other administrative or judicial requirements outstanding under any Environmental Law with respect to the Borrower or any of the Subsidiaries, the Subject Properties or the Businesses.

(f) There has been no release or threat of release of Hazardous Materials at or from the Subject Properties, or arising from or related to the operations (including, without limitation, disposal) of the Borrower or any of the Subsidiaries in connection with the Subject Properties or otherwise in connection with the Businesses, in violation of, or in amounts or in a manner that could give rise to liability under, Environmental Laws.

Section 5.13 Security Documents.

(a) The Security Agreement is effective to create in favor of the Administrative Agent, for the ratable benefit of the Secured Parties, a legal, valid and enforceable security interest in the Collateral identified therein owned by the Loan Parties who are a party thereto, and, when financing statements in appropriate form are filed in the appropriate offices for the locations specified in the schedules to the Security Agreement, the Security Agreement shall constitute a fully perfected Lien on, and security interest in, all right, title and interest of the grantors thereunder in such Collateral that may be perfected by filing, recording or registering a financing statement under the UCC as in effect, in each case prior and superior in right to any other Lien on any Collateral other than Permitted Liens.

(b) The Pledge Agreement is effective to create in favor of the Administrative Agent, for the ratable benefit of the Secured Parties, a legal, valid and enforceable security interest in the Collateral identified therein, and, when such Collateral is delivered to the Administrative Agent, the Pledge Agreement shall constitute a fully perfected first priority Lien on, and security interest in, all right, title and interest of the pledgors thereunder in such Collateral, in each case subject to no other Lien other than Permitted Liens.

(c) The Security Agreement, together with the Notice of Grant of a Security Interest in Trademarks when duly recorded in the United States Patent and Trademark Office, will constitute a fully perfected Lien on, and security interest in, all right, title and interest of the grantors thereunder in all Trademarks and Trademark Licenses (each as defined in the Security Agreement) owned by such grantors and in which a security interest may be perfected by filing, recording or registration of a Notice in the United States Patent and Trademark Office, in each case prior and superior in right to any other Lien other than Permitted Liens.

Section 5.14 Insurance. The Borrower and the Subsidiaries maintain, with financially sound and reputable insurance companies not Affiliates of the Borrower, insurance (including workers' compensation, liability insurance and casualty insurance), with respect to its properties and business against loss or damage of the kinds customarily insured against by Persons engaged in the same or similar businesses and owning similar properties in localities where the Borrower

or such Subsidiary operates, of such types and in such amounts, with such deductibles and covering such risks, as are customarily carried under similar circumstances by such other Persons (or otherwise required in the Collateral Documents). The present insurance coverage of the Borrower and each of the Subsidiaries is described as to name of insured, carrier, policy number, expiration date, type and amount on Schedule 5.14.

Section 5.15 Taxes. The Borrower and each of the Subsidiaries have filed all Federal, state and other tax returns and reports required to be filed, and have paid all Federal, state and other taxes, assessments, fees and other governmental charges shown thereon to be due (including interest and penalties) and all other Federal, state and other taxes, assessments, fees and other governmental charges owing by it, except (i) which are not yet delinquent or (ii) that are being contested in good faith by appropriate proceedings diligently conducted and for which adequate reserves have been provided in accordance with GAAP (or as applicable, with respect to HMO Subsidiaries, SAP). To the knowledge of the Borrower, there is no pending investigation or proposed tax assessment against the Borrower or any of the Subsidiaries that would, if made, have a Material Adverse Effect.

Section 5.16 ERISA Compliance.

(a) Each Plan is in compliance in all material respects with the applicable provisions of ERISA, the Code and other Federal or state Laws. Each Plan that is intended to qualify under Section 401(a) of the Code has received a favorable determination letter from the IRS or an application for such a letter is currently being processed by the IRS with respect thereto and, to the best knowledge of the Borrower, nothing has occurred which would prevent, or cause the loss of, such qualification. The Borrower and each ERISA Affiliate have made all required contributions to each Plan subject to Section 412 of the Code, and no application for a funding waiver or an extension of any amortization period pursuant to Section 412 of the Code has been made with respect to any Plan.

(b) There are no pending or, to the actual knowledge of the Borrower, threatened claims, actions or lawsuits, or action by any Governmental Authority, with respect to any Plan that could reasonably be expected to have a Material Adverse Effect. There has been no prohibited transaction or violation of the fiduciary responsibility rules with respect to any Plan that has resulted or could reasonably be expected to result in a Material Adverse Effect.

(c) (i) No ERISA Event has occurred or is reasonably expected to occur; (ii) no Pension Plan has any Unfunded Pension Liability; (iii) neither the Borrower nor any ERISA Affiliate has incurred, or reasonably expects to incur, any liability under Title IV of ERISA with respect to any Pension Plan (other than premiums due and not delinquent under Section 4007 of ERISA); (iv) neither the Borrower nor any ERISA Affiliate has incurred, or reasonably expects to incur, any liability (and no event has occurred which, with the giving of notice under Section 4219 of ERISA, would result in such liability) under Sections 4201 or 4243 of ERISA with respect to a Multiemployer Plan; and (v) neither the Borrower nor any ERISA Affiliate has engaged in a transaction that could be subject to Sections 4069 or 4212(c) of ERISA.

Section 5.17 Margin Regulations; Investment Company Act; Public Utility Holding Company Act.

(a) The Borrower is not engaged, and will not engage, principally or as one of its important activities, in the business of purchasing or carrying margin stock (within the meaning of Regulation U issued by the FRB), or extending credit for the purpose of purchasing or carrying margin stock, and no proceeds of any Loans or drawings under any Letter of Credit will be used to purchase or carry any margin stock or to extend credit to others for the purpose of purchasing or carrying margin stock.

(b) None of the Borrower, any Person Controlling the Borrower, or any Subsidiary (i) is a "holding company," or a "subsidiary company" of a "holding company," or an "affiliate" of a "holding company" or of a "subsidiary company" of a "holding company," within the meaning of the Public Utility Holding Company Act of 1935, or (ii) is or is required to be registered as an "investment company" under the Investment Company Act of 1940. Neither the making of the Loans, nor the issuance of the Letters of Credit or the application of the proceeds or repayment thereof by the Borrower, nor the consummation of other transactions contemplated hereunder, will violate any provision of any such Act or any rule, regulation or order of the SEC.

Section 5.18 Disclosure. The Borrower has disclosed to the Administrative Agent and the Lenders all agreements, instruments and corporate or other restrictions to which it or any of the Subsidiaries is subject, and all other matters known to it, that, individually or in the aggregate, could reasonably be expected to result in a Material Adverse Effect. No written report, financial statement, certificate or other written information furnished by or on behalf of any Loan Party or any of their respective Subsidiaries to the Administrative Agent or any Lender in connection with the transactions contemplated hereby and the negotiation of this Agreement and the other Loan Documents or delivered hereunder or thereunder (as modified or supplemented by other information so furnished) contains any material misstatement of fact or omits to state any material fact necessary to make the statements therein, in the light of the circumstances under which they were made, not misleading; provided that, with respect to projected financial and projected operational information, the Borrower represents only that such information was prepared in good faith based upon assumptions believed by it to be reasonable at the time.

Section 5.19 Compliance with Laws. Each of the Borrower and its Subsidiaries is in compliance in all material respects with the requirements of all Laws (including, without limitation, HMO Regulations, Medicare Regulations and Medicaid Regulations applicable to it and its Properties) and all orders, writs, injunctions and decrees applicable to it or to its properties, except in such instances in which (a) such requirement of Law or order, writ, injunction or decree is being contested in good faith by appropriate proceedings diligently conducted or (b) the failure to comply therewith, either individually or in the aggregate, could not reasonably be expected to have a Material Adverse Effect. Without limiting the generality of the foregoing, with respect to the Borrower and each of the Subsidiaries:

(i) (A) neither the Borrower nor any of the Subsidiaries nor any individual employed by the Borrower or any of the Subsidiaries is reasonably expected to have criminal culpability or to be excluded from participation in any Medical

Reimbursement Program for corporate or individual actions or failures to act where such culpability or exclusion has resulted or could reasonably be expected to result in an Exclusion Event; and (B) there is no officer continuing to be employed by the Borrower or any of the Subsidiaries who may reasonably be expected to have individual culpability for matters under investigation by the OIG or other Governmental Authority relating to the Businesses unless such officer has been, within a reasonable period of time after discovery of such actual or potential culpability, either suspended or removed from positions of responsibility related to those activities under challenge by the OIG or other Governmental Authority;

(ii) current billing policies, arrangements, protocols and instructions comply with requirements of Medical Reimbursement Programs and are administered by properly trained personnel, except where any such failure to comply would not reasonably be expected to result in an Exclusion Event;

(iii) current medical director compensation arrangements comply with state and federal anti-kick back, fraud and abuse, and Stark I and II requirements, except where any such failure to comply would not reasonably be expected to result in an Exclusion Event; and

(iv) the Borrower and the Subsidiaries and their respective Affiliates have established and implemented such policies, programs, procedures, contracts and systems, as are necessary for the Borrower and the Subsidiaries and their respective Affiliates to comply with the Health Insurance Portability and Accountability Act of 1996; Title II, Subtitle F, Sections 161-264, Public Law 104-191 and the Standards for Privacy of Individually Identifiable Health Information, 45 C.F.R. Parts 160-164 as of the dates such establishment or implementation is required by such Laws.

Section 5.20 Labor Matters.

Except as would not reasonably be expected to have a Material Adverse Effect:

(a) There are no strikes or lockouts against the Borrower or any Subsidiary pending or, to the actual knowledge of the Borrower, threatened;

(b) The hours worked by and payments made to employees of the Borrower and the Subsidiaries have not been in violation of the Fair Labor Standards Act or any other applicable federal, state, local or foreign Law dealing with such matters in any case where a Material Adverse Effect could reasonably be expected to occur as a result of the violation thereof;

(c) All payments due from the Borrower or any of the Subsidiaries, or for which any claim may be made against the Borrower or any Subsidiary, on account of wages and employee health and welfare insurance and other benefits, have been paid or accrued as a liability on the books of the Borrower or such Subsidiary; and

(d) Neither the Borrower nor any of the Subsidiaries is a party to a collective bargaining agreement.

Set forth on Schedule 5.20 is a summary of all labor matters pending or, to the actual knowledge of the Borrower, threatened by or against the Borrower or any of the Subsidiaries, and none of such labor matters, individually or in the aggregate, could reasonably be expected to have a Material Adverse Effect.

Section 5.21 Fraud And Abuse. Neither the Borrower, any of the Subsidiaries nor any of their respective officers, directors or, to the actual knowledge of the Borrower, any Contract Provider, has engaged in any activities that are prohibited under Medicare Regulations or Medicaid Regulations or that are prohibited by binding rules of professional conduct which, individually or in the aggregate, could reasonably be expected to have a Material Adverse Effect.

Section 5.22 Licensing. The Borrower and each of the Subsidiaries and, to the actual knowledge of the Borrower, each Contract Provider, has, to the extent applicable (a) obtained (or been duly assigned) all required authorizations, consents, approvals, certificates of authority, certificates of need or determinations of need as required by the relevant state Governmental Authority for the acquisition, construction, expansion of, investment in or operation of its businesses as currently operated, (b) obtained and maintains all required licenses, and (c) entered into and maintains its status as a Medicare supplier and as a Medicaid supplier. To the actual knowledge of the Borrower, each Contract Provider is duly licensed by each state, state agency, commission or other Governmental Authority having jurisdiction over the provisions of such services by such Contract Provider in the locations where the Borrower or any of the Subsidiaries conduct business, to the extent such licensing is required to enable such Contract Provider to provide the professional services provided by such Contract Provider and otherwise as is necessary to enable the Borrower and the Subsidiaries to operate as currently operated and as contemplated to be operated. To the actual knowledge of the Borrower, all such required licenses are in full force and effect on the date hereof and have not been revoked or suspended or otherwise limited.

Section 5.23 Solvency. Immediately after giving effect to the initial Credit Extension made on the Closing Date, (a) the fair value of the assets of each of the Borrower and each of the Subsidiaries will exceed its debts and liabilities, subordinated, contingent or otherwise, (b) the present fair saleable value of the property of each of the Borrower and each of the Subsidiaries will be greater than the amount that will be required to pay the probable liability of its debts and other liabilities, subordinated, contingent or otherwise, as such debts and other liabilities become absolute and mature, and (c) each of the Borrower and each of the Subsidiaries will not have unreasonably small capital with which to conduct the business in which it is engaged as such business is now conducted and is proposed to be conducted following the Closing Date.

Section 5.24 Material Contracts. Set forth on Schedule 5.24 is a complete and accurate list of all Material Contracts of the Borrower and each of the Subsidiaries, showing as of the date hereof, the name thereof, the parties, the subject matter and the term. Each such Material Contract is in full force and effect and is binding upon and enforceable against the Borrower and each Subsidiary party thereto, (and to the actual knowledge of the Borrower, all other parties thereto) in accordance with its terms, except to the extent enforceability may be

limited by Debtor Relief Laws, and there exists no material default under any Material Contract by the Borrower or any of the Subsidiaries, or to the Borrower's actual knowledge, by any other party thereto.

ARTICLE VI
AFFIRMATIVE COVENANTS

So long as any Lender shall have any Commitment hereunder, any Loan or other Obligation hereunder shall remain unpaid or unsatisfied, or any Letter of Credit shall remain outstanding, the Borrower shall:

Section 6.01 Financial Statements. Deliver to the Administrative Agent and each Lender, in form and detail satisfactory to the Administrative Agent and the Required Lenders:

(a) as soon as available, but in any event within the earlier of ninety-five (95) days after the end of each fiscal year, or such shorter period required by the SEC (plus five (5) days) of the Borrower and the Subsidiaries, (i) consolidated and consolidating balance sheets of the Borrower and the Subsidiaries as at the end of such fiscal year, and the related consolidated and consolidating statements of income or operations, shareholders' equity and cash flows for such fiscal year, setting forth in each case in comparative form the figures for the previous fiscal year, all in reasonable detail and prepared in accordance with GAAP, audited and accompanied by a report and opinion of an independent certified public accountant of nationally recognized standing reasonably acceptable to the Required Lenders, which report and opinion shall be prepared in accordance with generally accepted auditing standards and shall not be subject to any "going concern" or like qualification or exception or any qualification or exception as to the scope of such audit, and (ii) with respect to each HMO Subsidiary, annual financial statements of such HMO Subsidiary prepared in accordance with SAP; and

(b) as soon as available, but in any event within the earlier of fifty (50) days after the end of each of the first three fiscal quarters of each fiscal year of the Borrower and the Subsidiaries, or such shorter period required by the SEC (plus five (5) days), (i) consolidated and consolidating balance sheets of the Borrower and the Subsidiaries as at the end of such fiscal quarter, and the related consolidated and consolidating statements of income or operations, shareholders' equity and cash flows for such fiscal quarter and for the portion of the Borrower's or the Subsidiaries' fiscal year then ended, setting forth in each case in comparative form the figures for the corresponding fiscal quarter of the previous fiscal year and the corresponding portion of the previous fiscal year, all in reasonable detail and certified by Responsible Officers of the Borrower as fairly presenting the consolidated and consolidating financial condition, results of operations, shareholders' equity and cash flows of the Borrower and the Subsidiaries in accordance with GAAP, subject only to normal year-end audit adjustments and the absence of footnotes, and (ii) with respect to each HMO Subsidiary, quarterly financial statements of such HMO Subsidiary prepared in accordance with SAP.

As to any information contained in materials furnished pursuant to Section 6.02(d), the Borrower shall not be separately required to furnish such information under subsection (a) or (b) above, but the foregoing shall not be in derogation of the obligation of the Borrower to furnish the

information and materials described in subsections (a) and (b) above at the times specified therein.

Section 6.02 Certificates; Other Information. Deliver to the Administrative Agent and each Lender, in form and detail satisfactory to the Administrative Agent and the Required Lenders:

(a) concurrently with the delivery of the financial statements referred to in Section 6.01(a), a certificate of its independent certified public accountants certifying such financial statements and stating that in making the examination necessary therefor no knowledge was obtained of any Default under the financial covenants set forth herein or, if any such Default shall exist, stating the nature and status of such Default setting forth the details of such Default and the action that the Borrower has taken or proposes to take with respect thereto;

(b) concurrently with the delivery of the financial statements referred to in Sections 6.01(a) and (b), a duly completed Compliance Certificate signed by Responsible Officers of the Borrower. In connection with the delivery by the Borrower of each Compliance Certificate pursuant to this Section 6.02(b), the Borrower shall deliver to the Administrative Agent supplements to Schedules 5.08, 5.11, 5.14, 5.20 and 5.24 and the report required by Section 6.15(c), together with a statement of the Responsible Officers executing the Compliance Certificate, certifying that, as of the date thereof, after giving effect to the supplements to such Schedules and such report delivered therewith, the representations and warranties in Article V hereof are true and correct in all material respects. In addition, for fiscal year 2003, no later than April 30, 2003 and for any fiscal year thereafter, concurrently with the delivery of the financial statements referred to in Section 6.01(a), a schedule signed by a Responsible Officer of the Borrower setting forth in reasonable detail the reinsurance arrangements maintained by each of the HMO Subsidiaries of the Borrower;

(c) promptly after receipt thereof, copies of any detailed audit reports, management letters or recommendations submitted to the board of directors (or the audit committee of the board of directors) of the Borrower or any of the Subsidiaries by independent accountants in connection with the accounts or books of the Borrower or any of the Subsidiaries, or any audit of any of them;

(d) promptly after the same are available, (i) copies of management discussion and analysis in relationship to the financial statements delivered pursuant to Sections 6.01(a) and 6.01(b), (ii) copies of each annual report, proxy or financial statement or other report or communication sent to the stockholders of the Borrower in their capacities as stockholders, and copies of all annual, regular, periodic and special reports and registration statements which the Borrower may file or be required to file with the SEC under Section 13 or 15(d) of the Securities Exchange Act of 1934, and not otherwise required to be delivered to the Administrative Agent pursuant hereto, and (iii) upon the request of the Administrative Agent, all reports and written information to and from the United States Environmental Protection Agency, or any state or local agency responsible for environmental matters, the United States Occupational Health and Safety Administration, or any state or local agency responsible for health and safety matters, or any successor or other agencies or authorities concerning environmental, health or safety matters;

(e) no later than the Closing Date for fiscal year 2003, and within forty-five (45) days following the end of each fiscal year of the Borrower thereafter, an annual business plan and budget of the Borrower and the Subsidiaries containing, among other things, summary pro forma financial information for the next fiscal year with respect to each calendar month and fiscal quarter; and

(f) as soon as reasonably practicable after the Borrower's receipt of a request thereof, promptly, such additional information regarding the business, financial or corporate affairs of the Borrower or any Subsidiary, or compliance with the terms of the Loan Documents, as the Administrative Agent or any Lender may from time to time reasonably request.

Documents required to be delivered pursuant to Sections 6.01(a) or (b) or Section 6.02(d) (to the extent any such documents are included in materials otherwise filed with the SEC) may be delivered electronically and if so delivered, shall be deemed to have been delivered on the date (i) on which the Borrower posts such documents, or provides a link thereto on the Borrower's website on the Internet at the website address listed on Schedule 10.02, or (ii) on which such documents are posted on the Borrower's behalf on IntraLinks/IntraAgency or another relevant website, if any, to which each Lender and the Administrative Agent have access (whether a commercial, third-party website or whether sponsored by the Administrative Agent); provided that, (i) the Borrower shall deliver paper copies of such documents to the Administrative Agent or any Lender that requests the Borrower to deliver such paper copies until a written request to cease delivering paper copies is given by the Administrative Agent or such Lender, and (ii) the Borrower shall notify (which may be by facsimile or electronic mail) the Administrative Agent and each Lender of the posting of any such documents and provide to the Administrative Agent by electronic mail electronic versions (i.e., soft copies) of such documents. Notwithstanding anything contained herein, in every instance the Borrower shall be required to provide paper copies of the Compliance Certificates required by Section 6.02(a) and (b) to the Administrative Agent. The Administrative Agent shall have no obligation to request the delivery or to maintain copies, except for such Compliance Certificate of the documents referred to above, and in any event shall have no responsibility to monitor compliance by the Borrower with any such request for delivery, and each Lender shall be solely responsible for requesting delivery to it or maintaining its copies of such documents.

Section 6.03 Notices. Promptly notify the Administrative Agent and each Lender:

(a) of the occurrence of any Default;

(b) of to the actual knowledge of the Borrower, (i) any material breach or non-performance of, or any material default under, a Material Contract of the Borrower or any Subsidiary, (ii) any material dispute, action, litigation, investigation or proceeding between the Borrower or any Subsidiary and any Governmental Authority, (iii) the commencement of, or any material development in, any material action, litigation, investigation or proceeding affecting the Borrower or any Subsidiary, including pursuant to any applicable Environmental Laws, (iv) the institution of any material action, litigation, investigation or proceeding against the Borrower or any Subsidiary (or, to the actual knowledge of the Borrower, any Contract Provider) to suspend, revoke or terminate (or that may result in termination of) its status as a Medicaid supplier or its status as a Medicare supplier, or any such investigation or proceeding that may result in an

Exclusion Event, (v) a copy of any notice of intent to exclude the Borrower or any of the Subsidiaries from participation in any Medical Reimbursement Program, any notice of proposal to exclude the Borrower or any of the Subsidiaries from participation in any Medical Reimbursement Program issued by the OIG, or any other Exclusion Event, (vi) a copy of any notice of loss of participation under any reimbursement program or loss of applicable health care license or certificate of authority of any HMO Subsidiary, and all other material deficiency notices, compliance orders or adverse reports issued by any HMO Regulator or other Governmental Authority or private insurance company pursuant to a provider agreement that, if not promptly complied with or cured, could reasonably be expected to result in the suspension or forfeiture of any license or certification necessary for such HMO Subsidiary to carry on its business as then conducted or the termination of any insurance or reimbursement program available to any HMO Subsidiary, or (vii) any correspondence received by the Borrower and any Subsidiary from an HMO Regulator asserting that the Borrower or any Subsidiary is not in compliance with HMO Regulations, or to the actual knowledge of the Borrower, threatening action against the Borrower or any Subsidiary under the HMO Regulations, which in either case could reasonably be expected to have a material adverse effect on the entity so notified;

(c) of the occurrence of any ERISA Event;

(d) of any material change in accounting policies or financial reporting practices by the Borrower or any Subsidiary; and

(e) within the period for delivery of the quarterly financial statements provided in Section 6.01(b), of any written notification of Investments during such fiscal quarter by the Borrower or any Subsidiary in any HMO Subsidiary that, individually or in the aggregate in any fiscal year of the Borrower, exceed ten percent (10%) of the Company Action Level or the relevant state's risk-based capital threshold, as applicable, (in each case as determined in accordance with SAP at the immediately preceding fiscal-year-end determination thereof) of such HMO Subsidiary; provided that, to the extent such Investments, individually or in the aggregate, materially deviate from the business plan and budget delivered pursuant to Section 6.02(e), written notification of such Investments shall be provided not later than fifteen days following the end of the calendar month during which such Investments are made.

Each notice pursuant to this Section shall be accompanied by a statement of a Responsible Officer of the Borrower setting forth details of the occurrence referred to therein and stating what action the Borrower has taken and proposes to take with respect thereto. Each notice pursuant to Section 6.03(a) shall describe with particularity any and all provisions of this Agreement and any other Loan Document that have been breached.

Section 6.04 Payment of Obligations. Pay and discharge, and cause each of the Subsidiaries to pay and discharge, as the same shall become due and payable, all its material obligations and liabilities, including (a) all tax liabilities, fees, assessments and governmental charges or levies upon it or its properties or assets, unless the same are being diligently contested in good faith by appropriate proceedings diligently conducted and adequate reserves in accordance with GAAP are being maintained, (b) all Indebtedness, as and when due and payable, but subject to any subordination provisions contained in any instrument or agreement evidencing such Indebtedness; provided that no violation of this clause (b) shall constitute an Event of

Default unless such violation is also an Event of Default under Section 8.01(e), and (c) all lawful claims that, if unpaid, could reasonably be expected to give rise to a Lien upon any of its properties, except, in each case to the extent being diligently contested in good faith by appropriate proceedings which suspend the enforcement of the Lien and for which adequate reserves in accordance with GAAP shall have been set aside on its books.

Section 6.05 Preservation of Existence, Etc. (a) Preserve, renew and maintain, and cause each of the Subsidiaries to preserve, renew and maintain, in full force and effect its legal existence, legal structure, legal name and good standing under the Laws of the jurisdiction of its incorporation or organization, except in a transaction permitted by Sections 7.04 or 7.05; (b) take all reasonable action, and cause each of the Subsidiaries to take all reasonable action, to maintain all rights (charter or statutory), privileges, permits, licenses, approvals and franchises in each case which are necessary in the normal conduct of its business, except in a transaction permitted by Sections 7.04 and 7.05; and (c) preserve or renew, and cause each of the Subsidiaries to preserve and renew, all of its registered patents, trademarks, trade names and service marks, except, in each case, where failure to do so could not reasonably be expected to have a Material Adverse Effect.

Section 6.06 Maintenance of Properties. Maintain, preserve and protect, and cause each of Subsidiaries to maintain, preserve and protect, all of its material properties and equipment necessary in the operation of its business in good working order and condition, ordinary wear and tear excepted, to the extent and in the manner customary for Persons engaged in similar businesses.

Section 6.07 Maintenance of Insurance. Maintain, and cause each of the Subsidiaries to maintain, with financially sound and reputable insurance companies not Affiliates of the Borrower, insurance (including workers' compensation, liability insurance and casualty insurance), with respect to its properties and business against loss or damage of the kinds customarily insured against by Persons engaged in the same or similar businesses and owning similar properties in localities where the Borrower or such Subsidiary operates, of such types and in such amounts, with such deductibles and covering such risks, as are customarily carried under similar circumstances by such other Persons (or otherwise required in the Collateral Documents). The Administrative Agent shall be named as loss payee and/or additional insured with respect to any such insurance providing coverage in respect of any Collateral, and each provider of any such insurance shall agree, by endorsement upon the policy or policies issued by it or by independent instruments furnished to the Administrative Agent, that it will give the Administrative Agent thirty (30) days prior written notice before any such policy or policies shall be altered or canceled, and that no act or default of the Borrower, any Subsidiary or any other Person shall affect the rights of the Administrative Agent or the Lenders under such policy or policies.

Section 6.08 Reinsurance Arrangements. Deliver a schedule at the time set forth in Section 6.02(b) signed by a Responsible Officer of the Borrower setting forth in reasonable detail the reinsurance arrangements maintained by each of the HMO Subsidiaries of the Borrower as of the end of such fiscal year (with any changes subsequent to the end of such fiscal year described therein).

Section 6.09 Compliance with Laws. Comply, and cause each of the Subsidiaries to comply, in all material respects with the requirements of all Laws and all orders, writs, injunctions and decrees applicable to it or to its business or property, to include, without limitation, compliance with HMO Regulations applicable to them in the operation of HMO Businesses, ERISA and the Racketeer Influenced and Corrupt Organization Chapter of the Organized Crime Control Act of 1970, except in such instances in which such requirement of Law or order, writ, injunction or decree is being contested in good faith by appropriate proceedings diligently conducted.

Section 6.10 Books and Records. (a) Maintain, and cause each of the Subsidiaries to maintain, proper books of record and account, in which full, true and correct entries in conformity with GAAP consistently applied shall be made of all financial transactions and matters involving the assets and business of the Borrower or such Subsidiary, as the case may be (and with respect to each HMO Subsidiary, in accordance with SAP); and (b) maintain, and cause each of the Subsidiaries to maintain, such books of record and account in material conformity with all applicable requirements of any Governmental Authority having regulatory jurisdiction over the Borrower or such Subsidiary, as the case may be.

Section 6.11 Inspection Rights. Permit, and cause each of the Subsidiaries to permit, representatives and independent contractors of the Administrative Agent and each Lender to visit and inspect any of its properties, to examine its corporate, financial and operating records, and make copies thereof or abstracts therefrom, subject, in each case to applicable Laws of Governmental Authorities regarding confidentiality of patient health information and other confidentiality restrictions of Governmental Authorities to which the Borrower and its Subsidiaries are bound, and to discuss its affairs, finances and accounts with its directors, officers, and independent public accountants, and at such reasonable times during normal business hours and as often as may be reasonably desired, upon reasonable advance notice to the Borrower; provided, however, that notwithstanding anything to the contrary contained herein (including Section 10.04), only when an Event of Default exists may the Administrative Agent or any Lender (or any of their respective representatives or independent contractors) do any of the foregoing at the expense of the Borrower at any time during normal business hours and without advance notice. The Borrower agrees that the Administrative Agent and its representatives may conduct an annual audit of the Collateral, at the expense of the Borrower.

Section 6.12 Use of Proceeds. In the case of the Borrower, use the proceeds of the Credit Extensions (a) to pay fees and expenses incurred in connection with the Loan Documents, (b) to provide for working capital for the Borrower and the Subsidiaries in accordance with the provisions of this Agreement, (c) for Permitted Acquisitions; (d) for the Permitted Stock Redemption/ESOP Transactions ;provided that in no event shall more than $20 million in the aggregate be borrowed for such purpose during the term of this Agreement; and (e) for other general corporate purposes not in contravention of any Law or of any Loan Document (including a borrowing of an aggregate amount of no more than $3.4 million to repay the Building Finance Loan subject to the simultaneous release of the Lien securing the Building Finance Loan).

Section 6.13 Further Assurances with Respect to Eligible Subsidiaries. (a) Notify the Administrative Agent at the time that any Person becomes an Eligible Subsidiary, (b) promptly thereafter (and in any event within thirty (30) days), cause such Person to (i) become a

Guarantor by executing and delivering to the Administrative Agent the Subsidiary Guaranty, or if the Subsidiary Guaranty has been executed and delivered by another Guarantor, a Joinder Agreement and such other documents as the Administrative Agent shall deem appropriate for such purpose, (ii) perfect and maintain the validity, effectiveness and any priority of security interests in all of its personal property, assets and all proceeds and accessories therefrom to secure the Obligations as contemplated herein and in the Collateral Documents by executing and delivering the Security Agreement, or if the Security Agreement has been executed and delivered by another Eligible Subsidiary, a Joinder Agreement and such other documents as the Administrative Agent shall deem appropriate for such purpose, and (iii) become a party to or execute all applicable Collateral Documents, as determined by the Administrative Agent and such other documents as the Administrative Agent shall deem appropriate for such purpose, (c) promptly thereafter (and in any event within thirty (30) days) pledge and maintain a pledge of one hundred percent (100%) of the capital stock of such Eligible Subsidiary and (d) promptly thereafter (and in any event within thirty (30) days) deliver, and cause such Person to deliver, to the Administrative Agent documents of the types referred to in clauses (iii), (iv), (vi), (viii), (ix), (x), (xi), (xii), (xiii), (xiv), (xv), (xvi) and (xvii) of Section 4.01(a) and favorable opinions of counsel to the Borrower and such Eligible Subsidiary (which shall cover, among other things, the legality, validity, binding effect and enforceability of the documentation referred to in subsection (a) of Section 4.01), all in form, content and scope reasonably satisfactory to the Administrative Agent.

Section 6.14 Further Assurances with Respect to HMO Subsidiaries. (a) After the consummation of the initial public offering of the Borrower, the Borrower (i) shall use commercially reasonable efforts to obtain any necessary consents and/or make any necessary filings in order to transfer the ownership of Molina Healthcare of Michigan from Molina Healthcare of California to the Borrower and (ii) if ownership is so transferred, shall obtain, or cause to be obtained, any necessary consents and/or make any necessary filings in order to pledge to the Administrative Agent one hundred percent (100%) of the capital stock of Molina Healthcare of Michigan and shall take any and all action necessary or reasonably requested by the Administrative Agent to maintain the pledge of all such capital stock.

(b) In the event the HMO Regulations in California change or the undertaking agreement which prohibits the pledge of the capital stock of Molina Healthcare of California or any of its Subsidiaries to secure a loan to the Borrower or any of its Subsidiaries is terminated or changed at a date in the future to permit the pledge of the capital stock of Molina Healthcare of California or any of its Subsidiaries, the Borrower shall be required to take, or cause to be taken, commercially reasonable efforts to pledge one hundred percent (100%) of the capital stock of the Molina Healthcare of California and its Subsidiaries.

(c) (i) Notify the Administrative Agent at any time that any other Person becomes an HMO Subsidiary, (ii) promptly thereafter (and in any event within thirty (30) days) cause such Person to (A) become a party to and execute all applicable Collateral Documents, as determined by the Administrative Agent and such other documents as the Administrative Agent shall deem appropriate for such purpose and (B) deliver to the Administrative Agent documents of the type referred to in clauses (iii), (iv), (vi), (viii), (ix), (xi), (xv), (xvi) and (xvii) of Section 4.01(a) and (iii) pledge and maintain the pledge of one hundred percent (100%) of the capital

stock of such HMO Subsidiary (subject to no Liens); provided, however with respect to a Permitted Acquisition by Molina Healthcare of California or Molina Healthcare of Michigan, while a wholly-owned Subsidiary of Molina Healthcare of California, the actions specified in clauses (i) and (ii) of this clause (c) shall only be required to the extent permitted by applicable Law.

Section 6.15 Further Assurances with Respect to other Collateral.

(a) To the fullest extent permitted by applicable Law, execute, and cause each of the Subsidiaries (to the extent appropriate) to execute, any and all further documents, financing statements, agreements and instruments, and take all such further actions (including the filing and recording of financing statements, fixture filings, mortgages, deeds of trust and other documents), which may be required under any applicable Law, or which the Administrative Agent or the Required Lenders may reasonably request, to comply with the terms of this Agreement and the other Loan Documents, including causing, to the fullest extent permitted by Law, (i) the Collateral to be subject to a first priority security interest in favor of the Administrative Agent (subject, in the case of non-possessory security interests, to the Liens permitted by Section 7.01) and (ii) the pledge of the capital stock of the Subsidiaries which capital stock is subject to a pledge pursuant to the Pledge Agreement, in each case to secure all the Obligations, all at the expense of the Borrower. The Borrower also agrees to provide to the Administrative Agent, from time to time upon request, evidence reasonably satisfactory to the Administrative Agent as to the validity, perfection and priority of the Liens created or intended to be created by the Loan Documents.

(b) If any property or asset is acquired or leased by the Borrower or any of its Eligible Subsidiaries after the Closing Date, notify the Administrative Agent thereof (except, in the case of personal property, such notice shall not be required if the Administrative Agent has a valid first priority perfected security interest in such property and assets by virtue of any actions previously taken by or on behalf of the Administrative Agent), and cause, to the fullest extent permitted by Law, subject to the next succeeding sentence with respect to Real Property Assets acquired or leased after the Closing Date, such property and assets to be subjected to a first priority security interest, in the case of a Real Property Asset would be a first priority deed of trust, in favor of the Administrative Agent (subject, in the case of non-possessory security interests, to the Liens permitted by Section 7.01) take, and cause each of its Eligible Subsidiaries to take, to the fullest extent permitted by Law, such actions as shall be necessary or reasonably requested by the Administrative Agent or the Required Lenders to grant and perfect such Liens, including the actions described in subsection (a) and will obtain, and cause each of its Eligible Subsidiaries to obtain, Waiver Agreements with respect (i) to real property assets that are leased by the Borrower or any of its Eligible Subsidiaries and (ii) all such property and assets that are located in a public warehouse. The Borrower and any of its Eligible Subsidiaries shall only be required to provide a valid first priority perfected security interest in a Real Property Asset acquired after the Closing Date with a market value of $1 million or greater or a Real Property Asset in the form of a lease entered into after the Closing Date (i) with annual rent of $500,000 or greater, and (ii) wherein the granting of such lien does not cause a default by the Borrower or its Eligible Subsidiary under the lease; provided the Borrower makes a good faith effort to obtain

permission from landlord to grant such lien. With respect to any such Real Property Assets, the Borrower shall provide, or cause to be provided, the following:

(i) only with respect to any such Real Property Asset with a market value of $1,000,000 or greater, or any such leasehold Real Property Asset with annual rent of $500,000 or greater (and provided that the landlord consents thereto without additional cost or expense to the Borrower or its Eligible Subsidiary except for reasonable costs and legal fees of the landlord, the Borrower and the Administrative Agent), an as-built survey of the sites of the Mortgaged Property (and floor plans for leasehold interests) that are certified to the Administrative Agent and the Title Insurance Company in a manner satisfactory to them, dated not more than 30 days prior to the date of the initial Credit Extension by an independent professional licensed land surveyor satisfactory to the Administrative Agent and the Title Insurance Company (as defined hereinafter), which surveys on which they are based shall be made in accordance with the Minimum Standard Detail Requirements for Land Title Surveys jointly established and adopted by the American Land Title Association and the American Congress on Surveying and Mapping in 1997 or 1999 and meeting the accuracy requirements as defined therein, and, without limiting the generality of the foregoing, there shall be surveyed and shown on such surveys the following: (A) a current "as-built" survey showing the location of any adjoining streets (including their widths and any pavement or other improvements), easements (including the recorded information with respect to all recorded instruments), the mean high water base line or other legal boundary lines of any adjoining bodies of water, fences, zoning or restriction setback lines, rights-of-way, utility lines to the points of connection and any encroachments; (B) all means of ingress and egress, certifying the amount of acreage and square footage, the address of the Mortgaged Property, the legal description of the Mortgaged Property, and also contain a location sketch of the Mortgaged Property; (C) the location of all improvements as constructed on the Mortgaged Property, all of which shall be within the boundary lines of the Mortgaged Property and conform to all applicable zoning ordinances, set-back lines and restrictions; (D) the location of any Improvements on the Mortgaged Property with the dimensions in relations to the lot and building lines; (E) the measured distances from the Improvements to be set back and specified distances from street or property lines in the event that deed restrictions, recorded plats or zoning ordinances require same; (F) all courses and distances referred to in the legal description, and the names of all adjoining owners on all sides of the Mortgaged Property, to the extent available; and (G) the flood zone designation, if any, in which the Mortgaged Property is located. The legal description of the applicable Mortgaged Property shall be shown on the face of each survey or affixed thereto, and the same shall conform to the legal description contained in the title policy described below;

(ii) A mortgagee's title insurance policy (or policies) or marked up unconditional binder for such insurance. Each such policy shall (A) be in an

amount satisfactory to the Administrative Agent, (B) be issued at ordinary rates, (C) insure that each Mortgage insured thereby creates a valid first Lien on, and security interest in, the Mortgaged Property (which for a leasehold Real Property Asset shall mean the leasehold interest of the Borrower and shall not include nor require encumbrance in any manner whatsoever the fee estate of the landlord of such Real Property Asset) free and clear of all Liens, except as reasonably acceptable to the Administrative Agent, (D) name the Administrative Agent for the benefit of the Lenders as the insured thereunder, (E) be in the form of ALTA Loan Policy - 1970 Form B (Amended 10/17/70 and 10/17/84) (or equivalent policies), if available, (F) contain such endorsements and affirmative coverage as the Administrative Agent may reasonably request in form and substance acceptable to the Administrative Agent, including, without limitation (to the extent applicable with respect to the relevant Mortgaged Property and available in the jurisdiction in which such Mortgaged Property is located), the following: variable rate endorsement; survey endorsement, but only as to such Real Property Assets for which a land survey is required pursuant to clause (i) above; comprehensive endorsement; zoning (ALTA 3.1 with parking added) endorsement, but only as to such Real Property Assets for which a land survey is required pursuant to clause (i) above; first loss, last dollar and tie-in endorsement; access coverage; separate tax parcel coverage; usury; doing business; subdivision; environmental protection lien; CLTA 119.2; contiguity coverage; and such other endorsements as the Administrative Agent shall reasonably require in order to provide insurance against specific risks identified by the Administrative Agent in connection with the Mortgaged Property (provided that all endorsements requested by the Administrative Agent shall be made based on the relative value of the Real Property Asset and the extent the requested endorsement is generally available at commercially reasonable rates) and (G) be issued by nationally recognized title companies (collectively, the "Title Insurance Company"), satisfactory to the Administrative Agent. The Administrative Agent shall have received evidence satisfactory to it that all premiums in respect of each such policy, all charges for mortgage recording tax, and all related expenses, if any, have been paid;

(iii) if requested by the Administrative Agent, and generally available for the Real Property Asset at commercially reasonable rates (but excluding a leasehold Real Property Asset where such insurance is not required or maintained under the terms of the subject lease), a policy of flood insurance that (A) covers any parcel of the Mortgaged Property that is located in a flood zone, and (B) is written in an amount not less than the outstanding principal amount of the Indebtedness secured by each relevant Mortgage or the maximum limit of coverage made available with respect to the particular type of Mortgaged Property under the National Flood Insurance Act of 1968, whichever is less;

(iv) a copy of (A) all documents listed as exceptions to title in, the title policy or policies referred to in clause (ii) above and (B) all other material documents affecting the Mortgaged Property in the possession or under the

control of the Borrower, including, for those Real Property Assets for which a land survey is requried under clause (i) above, including all building, construction, environmental and other permits, licenses, franchises, approvals, consents, authorizations and other approvals required in connection with the construction, ownership, use, occupation or operation of the Mortgaged Property; and

(v) evidence reasonably acceptable to the Administrative Agent that the Real Property Assets comply with applicable zoning ordinances, if any.

(c) At the time of delivery of the financial statements and reports required by Section 6.01(a), deliver a schedule of the Borrower setting forth (i) a list of registration numbers for all patents, trademarks, service marks, tradenames and copyrights awarded to the Borrower or any of its Eligible Subsidiaries since the last day of the immediately preceding fiscal year and (ii) a list of all patent applications, trademark applications, service mark applications, tradename applications and copyright applications submitted by the Borrower or any of its Eligible Subsidiaries since the last day of the immediately preceding fiscal year and the status of each application, all in such form as shall be reasonably satisfactory to the Administrative Agent.

Section 6.16 Performance of Material Contracts. Do the following, and cause each of the Subsidiaries to do the following: (a) perform and observe all the terms and provisions of each Material Contract to be performed or observed by it; and (b) maintain each such Material Contract in full force and effect, enforce each such Material Contract in accordance with its terms, except, in either case, where the failure to do so, either individually or in the aggregate, could not be reasonably likely to have a Material Adverse Effect.

Section 6.17 Maintenance of Licensing, Etc. Preserve and maintain, and cause each of the HMO Subsidiaries to preserve and maintain, (a) the licensing and certification of each HMO Subsidiary pursuant to the HMO Regulations, (b) all certifications and authorizations necessary to ensure that the HMO Subsidiaries are eligible for all reimbursements available under the HMO Regulations to the extent applicable to HMOs owned by the Borrower or any of the Subsidiaries in their respective jurisdictions and (c) all licenses, permits, authorizations and qualifications required under the HMO Regulations in connection with the ownership or operation of HMOs.

Section 6.18 Environmental. (a) Upon the reasonable written request of the Administrative Agent following the occurrence of any event or the discovery of any condition that the Administrative Agent or the Required Lenders reasonably believe has caused (or could be reasonably expected to cause) the representations and warranties set forth in Section 5.12 to be untrue in any material respect, furnish or cause to be furnished to the Administrative Agent, at the Borrower's expense, a report of an environmental assessment of reasonable scope, form and depth, (including, where appropriate, invasive soil or groundwater sampling) by a consultant reasonably acceptable to the Administrative Agent as to the nature and extent of the presence of Hazardous Materials on any Subject Properties and as to the compliance by the Borrower and each Subsidiary with Environmental Laws at such Subject Properties. If the Borrower fails to deliver such an environmental report within 75 days after receipt of such written request then the

Administrative Agent may arrange for the same, and the Borrower and each of the Subsidiaries hereby grant to the Administrative Agent and their representatives access to the Subject Properties to reasonably undertake such an assessment (including, where appropriate, invasive soil or groundwater sampling). The reasonable cost of any assessment arranged for by the Administrative Agent pursuant to this provision will be payable by the Borrower on demand and added to the obligations secured by the Collateral Documents.

(b) Conduct and complete, and cause each of the Subsidiaries to conduct and complete, all investigations, studies, sampling, and testing and all remedial, removal, and other actions necessary to address all Hazardous Materials on, from or affecting any of the Subject Properties to the extent necessary for the Borrower and its Subsidiaries to be in compliance with all Environmental Laws and with the validly issued orders and directives of all Governmental Authorities with jurisdiction over such Subject Properties to the extent any failure could have a Material Adverse Effect.

ARTICLE VII
NEGATIVE COVENANTS

So long as any Lender shall have any Commitment hereunder, any Loan or other Obligation hereunder shall remain unpaid or unsatisfied, or any Letter of Credit shall remain outstanding, the Borrower shall not, directly or indirectly:

Section 7.01 Liens. Create, incur, assume or suffer to exist, or permit any Subsidiary to create, incur, assume or suffer to exist, any Lien upon any of its property, assets or revenues, whether now owned or hereafter acquired, other than the following (collectively, the "Permitted Liens"):

(a) Liens pursuant to any Loan Document;

(b) Liens existing on the date hereof and listed on Schedule 7.01 and any renewals or extensions thereof; provided that the property covered thereby is not increased and any renewal or extension of the obligations secured or benefited thereby is permitted by Section 7.03(b);

(c) Liens for taxes, fees, assessments or other governmental charges not yet due or which are not delinquent or remain payable without penalty, or to the extent non-payment thereof is permitted by Section 6.04; provided that no notice of Lien has been filed or recorded under the Code unless such is being contested in good faith and by appropriate proceedings diligently conducted and adequate reserves with respect thereto are maintained on the books of the applicable Person in accordance with GAAP;

(d) carriers', warehousemen's, mechanics', materialmen's, repairmen's or other like Liens arising in the ordinary course of business which are not delinquent or which are being contested in good faith and by appropriate proceedings, which proceedings have the effect of preventing the forfeiture or sale of the property subject thereto;

(e) pledges or deposits in the ordinary course of business in connection with workers' compensation, unemployment insurance and other social security legislation, other than any Lien imposed by ERISA;

(f) easements, rights-of-way, restrictions and other similar encumbrances affecting real property incurred in the ordinary course of business which do not in any case materially detract from the value of the property subject thereto or materially interfere with the ordinary conduct of the business of the applicable Person;

(g) Liens securing judgments for the payment of money not constituting an Event of Default under Section 8.01(h) or securing appeal or other surety bonds related to such judgments; provided that enforcement of such Liens is effectively stayed;

(h) Liens securing Indebtedness permitted under Section 7.03(e); provided that (i) any such Lien attaches to such property concurrently with or within 45 days of the acquisition thereof, (ii) such Lien does not at any time encumber any property other than the property financed by such Indebtedness, and (iii) the Indebtedness secured thereby does not exceed 100% of the cost or fair market value, whichever is lower, of the property being acquired on the date of acquisition;

(i) any interest or title of a lessor under, and Liens arising from UCC financing statements relating to, leases permitted by this Agreement; and

(j) Liens created or deemed to exist by the establishment of trusts for the purpose of satisfying (i) Governmental Reimbursement Program Costs and (ii) other actions or claims pertaining to the same or related matters; provided that the Borrower in its reasonable discretion in each case shall have established adequate reserves for such claims or actions.

Section 7.02 Investments. Make or hold, or permit any of the Subsidiaries to make or hold, any Investments in any Person, except:

(a) Investments by the Loan Parties held in the form of cash equivalents or short-term marketable debt securities;

(b) Investments made prior to the Closing Date and set forth in Schedule 7.02;

(c) Advances or loans to directors, officers and employees in the ordinary course of business of the Borrower and the Subsidiaries as presently conducted in an aggregate principal amount not to exceed $1 million in the aggregate at any one time outstanding; provided, however that any such advances or loans to directors or executive officers shall only be permitted to the extent allowable under Sarbanes-Oxley;

(d) Investments by the Borrower in and to any Loan Party in the form of contributions to capital or loans or advances; provided that (i) immediately before and after giving effect thereto, no Default exists or would result therefrom, (ii) each item of intercompany Indebtedness shall be unsecured and (iii) each item of Intercompany Indebtedness shall be evidenced by an Intercompany Note which shall be pledged as security for the Obligations of the

holder thereof under the Loan Documents and delivered to the Administrative Agent pursuant to the terms of the Collateral Documents;

(e) Investments by any Subsidiary in the Borrower or any other Loan Party in the form of loans or advances;

(f) Investments in any HMO Subsidiaries which are not Loan Parties, and any other Subsidiaries which are not Loan Parties; provided that such Investment (other than Investments in HMO Subsidiaries required for capital adequacy requirements) shall not exceed in an aggregate amount $2.5 million at any time outstanding (on a cost basis);

(g) Investments that constitute Permitted Acquisitions and Investments that constitute the Permitted Stock Redemption/ESOP Transactions;

(h) (i) Required Advances and (ii) other advances to Contract Providers (and their Affiliates) in an amount not to exceed (A) with respect to any Contract Provider (and its Affiliates) individually, $1 million in the aggregate at any time outstanding (excluding Required Advances) and (B) with respect to Contract Providers collectively, $5 million in the aggregate at any time outstanding (excluding Required Advances);

(i) Investments by the Borrower in Swap Contracts permitted under Section 7.03(d); and

(j) Investments of a nature not addressed in any of the foregoing subsections in an amount not to exceed $2.5 million in the aggregate at any time outstanding.

Section 7.03 Indebtedness. Create, incur, assume or suffer to exist, or permit any Subsidiary to create, incur, assume or suffer to exist, any Indebtedness, except:

(a) Indebtedness under the Loan Documents;

(b) Indebtedness outstanding on the date hereof and listed on Schedule 7.03 and any refinancings, refundings, renewals or extensions thereof; provided that the amount of such Indebtedness is not increased at the time of such refinancing, refunding, renewal or extension except by an amount equal to a reasonable premium or other reasonable amount paid, and fees and expenses reasonably incurred, in connection with such refinancing and by an amount equal to any existing commitments unutilized thereunder;

(c) Guarantees of any Guarantor in respect of Indebtedness otherwise permitted hereunder of the Borrower;

(d) obligations (contingent or otherwise) of the Borrower existing or arising under any Swap Contract; provided that (i) such obligations are (or were) entered into by such Person in the ordinary course of business for the purpose of directly mitigating risks associated with liabilities, commitments, investments, assets, or property held or reasonably anticipated by such Person, or changes in the value of securities issued by such Person, and not for purposes of speculation or taking a "market view," and (ii) such Swap Contract does not contain any

provision exonerating the non-defaulting party from its obligation to make payments on outstanding transactions to the defaulting party;

(e) Indebtedness in respect of Capitalized Leases and purchase money obligations for fixed or capital assets within the limitations set forth in the proviso in Section 7.01(h); provided, however, that the aggregate amount of all such Indebtedness at any one time outstanding shall not exceed $5 million;

(f) Intercompany Indebtedness permitted under Section 7.02(d);

(g) Indebtedness arising or existing with respect to Governmental Reimbursement Program Costs; and

(h) so long as no Default has occurred and is continuing or would result therefrom, additional unsecured Indebtedness of the Borrower, any Loan Party or any wholly-owned Subsidiary of the Borrower whose stock is pledged pursuant to the Pledge Agreement not covered in the foregoing clauses in an aggregate principal amount not to exceed $5 million at any time outstanding pre-Successful IPO and $10 million at any time outstanding post-Successful IPO; provided that such Indebtedness is not senior in right of payment to the payment of the Indebtedness arising under this Agreement and the Loan Documents.

Section 7.04 Fundamental Changes and Acquisitions.

(a) Merge, dissolve, liquidate, consolidate with or into another Person, or Dispose of, or permit any of the Subsidiaries to merge, dissolve, liquidate, consolidate with or into another Person, or Dispose of, (whether in one transaction or in a series of transactions) all or substantially all of its assets (whether now owned or hereafter acquired) to or in favor of any Person, except that, so long as no Default exists or would result therefrom:

(i) Molina Healthcare, Inc., a California corporation, may effect a reincorporation by merger with and into Molina Healthcare, Inc., a Delaware corporation with Molina Healthcare, Inc., a Delaware corporation, being the surviving entity pursuant to and in accordance with the Reincorporation Merger Documents; provided that: (A) no Default exists or would result from such action; (B) satisfactory evidence is provided that no dissenters' rights exist with respect to the existing shareholders of Molina Healthcare, Inc., a California corporation, and all requisite shareholder approval of Molina Healthcare, Inc., a California corporation, and Molina Healthcare, Inc., a Delaware corporation, has been obtained and is in full force and effect; (C) all Obligations under the Loan Documents shall continue in full force and effect after Molina Healthcare, Inc., a California corporation, effects the reincorporation by merger with and into Molina Healthcare, Inc., a Delaware corporation, on the same terms as applicable to Molina Healthcare, Inc., a California corporation, and the existing Subsidiary Guaranty shall remain in full force and effect and the Liens under the Collateral Documents shall remain in place with the same perfection and priority as required in the Loan Documents; (D) Molina Healthcare, Inc., a Delaware corporation, shall become the Borrower hereunder and under the Collateral Documents, shall execute and deliver an assumption agreement in form and substance satisfactory to the Administrative Agent and the Lenders and

Molina Healthcare, Inc., a Delaware corporation, and the Loan Parties shall take such other actions as the Administrative Agent reasonably deems necessary;

(ii) a Loan Party may merge with the Borrower; provided that the Borrower shall be the continuing or surviving Person;

(iii) a Loan Party (other than the Borrower) may be party to a transaction of merger or consolidation with another Loan Party;

(iv) a Subsidiary may be a party to a transaction of merger or consolidation with a Person other than the Borrower or any Subsidiary; provided that (A) the surviving entity shall be a wholly-owned Subsidiary and shall execute and deliver such Joinder Agreement, Pledge Agreement, Security Agreement and Intercompany Notes, as applicable, and take other such action as may be necessary for compliance with the provisions of Sections 6.13, 6.14 and 6.15, and (B) the transaction shall otherwise constitute a Permitted Acquisition; and

(v) a Subsidiary may enter into a transaction of merger or consolidation in connection with a Disposition permitted under Section 7.05.

(b) Permit the Borrower or any Subsidiary to make any Acquisition, unless:

(i) in the case of an acquisition of capital stock of another Person, after giving effect to such acquisition,

(A) if the Acquisition is not of a controlling interest in the subject Person such that after giving effect thereto the subject Person will not be a Subsidiary, then such Acquisition will constitute an Investment permitted by Section 7.02; and

(B) if the Acquisition is of a controlling interest in the subject Person such that after giving effect thereto the subject Person will be a Subsidiary, then such Acquisition will constitute a Permitted Acquisition; and

(ii) in the case of an Acquisition of all or any substantial portion of the Property (other than capital stock) of another Person, then such Acquisition will constitute a Permitted Acquisition.

Section 7.05 Dispositions. Make any Disposition or permit any Subsidiary to make any Disposition, except:

(a) Dispositions of obsolete or worn out property, whether now owned or hereafter acquired, in the ordinary course of business;

(b) Dispositions of inventory in the ordinary course of business;

(c) Dispositions of equipment or real property to the extent that (i) such property is exchanged for credit against the purchase price of similar replacement property or (ii)

the proceeds of such Disposition are reasonably promptly applied to the purchase price of similar replacement property;

(d) Dispositions of property to a Loan Party;

(e) Dispositions permitted by Section 7.04; and

(f) non-exclusive licenses of IP Rights in the ordinary course of business and substantially consistent with past practice for terms not exceeding five years;

provided, however, that any Disposition pursuant to subsections (a) through (f) shall be for fair market value.

Section 7.06 Restricted Payments. Make, or permit any Subsidiary to make, any Restricted Payment; provided that:

(i) the Borrower may so long as no Default exists or would result from such action, (A) make the redemptions and purchases in connection with Permitted Stock Redemption/ESOP Transactions; provided that after giving effect to any Permitted Stock Redemption/ESOP Transactions on a Pro Forma Basis and any Credit Extension related thereto, the Consolidated Leverage Ratio is less than 1.0 times and (B) take the actions contemplated in the Reincorporation Merger Documents in accordance with the provisions set forth in the proviso of Section 7.04(a)(i);

(ii) the Borrower may declare and pay dividends and distributions and finance the costs of Permitted Acquisitions payable solely in common stock of the Borrower; and

(iii) any Subsidiary may declare and pay dividends to the Borrower or any wholly-owned Subsidiary of the Borrower.

Section 7.07 Amendment, Etc. of Indebtedness, Other Material Contracts and Constitutive Documents and Payments in respect of Indebtedness.

(a) After the issuance thereof, amend or modify (or permit the amendment or modification of (including any waivers of)), or permit any Subsidiary to amend or modify (or permit the amendment or modification of (including any waivers of)), the terms of any Indebtedness in a manner adverse in any material respect to the interests of the Lenders (including, without limitation, specifically shortening any maturity or average life to maturity or requiring any payment sooner than previously scheduled or increasing the interest rate or fees applicable thereto).

(b) Cancel or terminate any other Material Contract or consent to or accept any cancellation or termination thereof by any Subsidiary, amend or modify (or permit the amendment or modification of (including any waivers of)), or permit any Subsidiary to amend or modify (or permit the amendment or modification of (including waivers of)), any Material Contract, waive, or permit any Subsidiary to waive, any default under or breach any Material Contract, unless, in each case, any such cancellation termination, amendment or modification, or

consent, waiver or approval thereunder could not reasonably be expected to have a Material Adverse Effect.

(c) Amend, or permit any of the Subsidiaries to amend, its Organization Documents, unless, in each case, any such amendment is not adverse in any material respect to the Lenders.

(d) Make any payment, or permit any Subsidiary to make any payment, in contravention of the terms of any subordination with respect to any Indebtedness.

(e) Except in connection with a refinancing or refunding permitted hereunder, make any prepayment, redemption, defeasance or acquisition for value (including, without limitation, by way of depositing money or securities with the trustee with respect thereto before due for the purpose of paying when due), or refund, refinance or exchange, or permit any Subsidiary to make any prepayment, redemption, defeasance or acquisition for value (including, without limitation, by way of depositing money or securities with the trustee with respect thereto before due for the purpose of paying when due), or refund, refinance or exchange, of any Indebtedness (other than the Indebtedness under the Loan Documents and intercompany Indebtedness permitted hereunder) other than regularly scheduled payments of principal and interest on such Indebtedness.

Section 7.08 Change in Nature of Business. Make, or permit any Subsidiary to make, any material change in the nature of its business as carried on at the date hereof.

Section 7.09 Transactions with Affiliates. Except for certain existing transactions specifically set forth on Schedule 7.09, enter into or permit to exist, or permit any Subsidiary to enter into or permit to exist, any transaction or series of transactions with any Affiliate of the Borrower, whether or not in the ordinary course of business, other than on fair and reasonable terms and conditions substantially as favorable to the Borrower or such Subsidiary as would be obtainable by it in a comparable arms-length transaction with a Person other than an Affiliate; provided, however, other than in connection with transactions pursuant to the Administrative Services Agreements, the Borrower shall not, and shall not permit any of the Subsidiaries to, enter into any transaction with an Affiliate if the amount to be paid pursuant to any one such transaction (whether immediately or over time) exceeds $2 million in the aggregate or for all transactions if the amount to be paid pursuant to such transactions (whether immediately or over time) exceeds $10 million in the aggregate during the term of this Agreement.

Section 7.10 Limitations on Restricted Actions. Enter into or create or otherwise cause to exist or become effective, or permit any Subsidiary to enter into or create or otherwise cause to exist or become effective, any agreement or arrangement that: (a) limits the ability (i) of any Subsidiary to make Restricted Payments to the Borrower or to otherwise transfer property to the Borrower, (ii) of any Subsidiary to Guarantee the Indebtedness of the Borrower or (iii) of the Borrower or any Subsidiary to create, incur, assume or suffer to exist Liens on property of such Person; provided, however, that this clause (iii) shall not prohibit (A) any negative pledge incurred or provided in favor of any holder of Indebtedness permitted under Section 7.03(e) solely to the extent any such negative pledge relates to the property financed by or the subject of such Indebtedness or (B) any amendments to or modifications of any undertaking between

Molina Healthcare of California and Government Authorities in California solely with respect to Molina Healthcare of California but only to the extent the amendments and modifications could not reasonably be expected to have a material adverse effect on Molina Healthcare of California; or (b) requires the grant of a Lien to secure an obligation of such Person if a Lien is granted to secure another obligation of such Person.

Section 7.11 Operating Lease Obligations. Enter into, assume or permit to exist, or allow any Subsidiary to enter into, assume or permit to exist, any obligations for the payment of rent under Operating Leases that in the aggregate would exceed $10 million in any fiscal year.

Section 7.12 Use of Proceeds. Use the proceeds of any Credit Extension, whether directly or indirectly, and whether immediately, incidentally or ultimately, to purchase or carry margin stock (within the meaning of Regulation U of the FRB) or to extend credit to others for the purpose of purchasing or carrying margin stock or to refund indebtedness originally incurred for such purpose.

Section 7.13 Impairment of Security Interests. Permit any Loan Party or any of their respective Subsidiaries to (a) take or omit to take any action which action or omission might or would materially impair the security interests in favor of the Administrative Agent with respect to the Collateral or (b) grant to any Person (other than the Administrative Agent pursuant to the Collateral Documents) any interest whatsoever in the Collateral, except for Permitted Liens.

Section 7.14 Ownership of Subsidiaries, Foreign Subsidiaries and Other Restrictions Relating to Subsidiaries.

(a) Ownership of Subsidiaries. Notwithstanding any other provisions of this Agreement to the contrary, (i) permit any Person (other than the Borrower or any wholly-owned Subsidiary; provided that Molina Healthcare of California and, so long as Molina Healthcare of Michigan is a wholly-owned Subsidiary of Molina Healthcare of California, Molina Healthcare of Michigan, both Subsidiaries of the Borrower, shall not have any such right, except to the extent permitted by the definition of Permitted Acquisition) to own any capital stock of any Subsidiary (except Molina Healthcare of California presently owns Molina Healthcare of Michigan, and except as a result of or in connection with a dissolution, merger, consolidation or disposition of a Subsidiary permitted under Section 7.04 or Section 7.05) or (ii) permit any Subsidiary to issue any shares of preferred capital stock.

(b) No Foreign Subsidiaries. Form or acquire, or cause any of the Subsidiaries to form or acquire, any Foreign Subsidiaries.

(c) Other Restrictions. Except as set forth in the final proviso of the definition of Permitted Acquisition, form or acquire, any new Subsidiaries of Molina Healthcare of California or, so long as Molina Healthcare of Michigan is a wholly-owned Subsidiary of Molina Healthcare of California, of Molina Healthcare of Michigan.

Section 7.15 Fiscal Year. Change its fiscal year, or permit any Subsidiary to change its fiscal year, unless such change is not adverse in any respect to the Lenders.

Section 7.16 Partnerships, etc. Become, or permit any Subsidiary to become, a general partner or limited partner or joint venture.

Section 7.17 Capital Expenditures. Make, or become legally obligated to make, any Capital Expenditure, except for Capital Expenditures determined on a consolidated basis in accordance with GAAP in the ordinary course of business not exceeding the aggregate amount of $15 million for the Borrower and the Subsidiaries during each fiscal year; provided, however, that so long as no Default has occurred and is continuing or would result from such Capital Expenditure, any portion of any amount set forth above, if not expended in the fiscal year for which it is permitted, may be carried over in an amount equal to 50% of the unused portion for Capital Expenditures in the next following fiscal year.

Section 7.18 Financial Covenants.

(a) Consolidated Net Worth. Permit Consolidated Net Worth at any time to be less than the sum of (i) $81 million, (ii) an amount equal to 50% of the Consolidated Net Income earned in each full fiscal quarter ending after March 31, 2003 (with no deduction for a net loss in any such fiscal quarter), (iii) 85% of net cash proceeds from the initial public offering of the Borrower, and (iv) an amount equal to 100% of net cash proceeds resulting from the aggregate increases in Shareholders' Equity of the Borrower and the Subsidiaries after the date of the initial public offering of the Borrower by reason of the issuance and sale of capital stock or other equity interests of the Borrower or any Subsidiary (other than issuances to the Borrower or a wholly-owned Subsidiary), including any conversion of debt securities of the Borrower into such capital stock or other equity interests, minus, $20.3 million for the stock redemption portion of the Permitted Stock Redemption/ESOP Transaction already consummated and minus, no more than $20 million for the ESOP portion of the Permitted Stock Redemption/ESOP Transaction upon the occurrence thereof.

(b) Fixed Charge Coverage Ratio. Permit the Fixed Charge Coverage Ratio as of the end of any fiscal quarter of the Borrower to be less than the ratio set forth below opposite the period in which such date occurs:

Four Fiscal Quarters Ending	Minimum Fixed Charge Coverage Ratio
Closing Date through June 30, 2004	1.6x
July 1, 2004 through June 30, 2005	1.25x
July 1, 2005 and each fiscal quarter thereafter	1.5x

(c) Consolidated Leverage Ratio. Permit the Consolidated Leverage Ratio at any time during any period of four fiscal quarters of the Borrower to be greater than 2.00:1.0.

Section 7.19 Risk-Based Capital Ratio. As of the end of each fiscal quarter:

(a) With respect to HMO Subsidiaries operating in a state in which regulatory action may be taken against HMOs that do not maintain a minimum risk-based capital threshold at a level equal to or greater than Company Action Level, permit each such HMO Subsidiary to maintain a ratio of Total Adjusted Capital to Risk-Based Capital at a level less than 1.10:1.00; and

(b) With respect to all other HMO Subsidiaries, permit each such HMO Subsidiary to maintain a ratio of Total Adjusted Capital to the applicable state's risk-based capital threshold at a level less than 1.25:1.00; provided if a state's risk-based capital threshold exceeds or would exceed the Company Action Level (if such state had adopted, or in the future adopts, the HMO Model Act), then permit each such HMO Subsidiary to maintain a ratio of Total Adjusted Capital to Risk-Based Capital at a level less than 1.10:1.00;

provided in each case for the first three fiscal quarters of each year, the denominator shall be the prescribed level as of the end of the preceding fiscal year, and for the last fiscal quarter of each year, the denominator shall be the prescribed level as of the end of such fiscal year.

ARTICLE VIII
EVENTS OF DEFAULT AND REMEDIES

Section 8.01 Events of Default. Any of the following shall constitute an Event of Default:

(a) Non-Payment. The Borrower or any other Loan Party fails to pay (i) when and as required to be paid herein, any amount of principal of any Loan or any L/C Obligation, or (ii) within three days after the same becomes due, any interest on any Loan or on any L/C Obligation, or any commitment or other fee due hereunder, or (iii) within five days after the same becomes due, any other amount payable hereunder or under any other Loan Document; or

(b) Specific Covenants. The Borrower fails to perform or observe any term, covenant or agreement contained in any of Section 6.01, 6.02, 6.03, 6.05, 6.12, 6.13, 6.14 or 6.15 or Article VII; or

(c) Other Defaults. The Borrower fails to perform or observe any other covenant or agreement (not specified in subsection (a) or (b) above) contained in any Loan Document on its part to be performed or observed and such failure continues for 30 days; or

(d) Representations and Warranties. Any representation, warranty, certification or statement of fact made or deemed made by or on behalf of the Borrower or any other Loan Party herein, in any other Loan Document, or in any document delivered in connection herewith or therewith shall be incorrect or misleading when made or deemed made; or

(e) Cross-Default. (i) The Borrower or any Subsidiary (A) fails to make any payment when due (whether by scheduled maturity, required prepayment, acceleration, demand, or otherwise) beyond the applicable grace period with respect thereto, if any in respect of (x) the

Building Finance Loan or (y) any other Indebtedness or Guarantee (other than Indebtedness hereunder and Indebtedness under Swap Contracts) having an aggregate principal amount (including undrawn committed or available amounts and including amounts owing to all creditors under any combined or syndicated credit arrangement) of more than the Threshold Amount, or (B) fails to observe or perform any other agreement or condition relating to any such Indebtedness or Guarantee or contained in any instrument or agreement evidencing, securing or relating thereto, or any other event occurs, the effect of which default or other event is to cause, or to permit the holder or holders of such Indebtedness or the beneficiary or beneficiaries of such Guarantee (or a trustee or agent on behalf of such holder or holders or beneficiary or beneficiaries) to cause, with the giving of notice if required, such Indebtedness to be demanded or to become due or to be repurchased, prepaid, defeased or redeemed (automatically or otherwise), or an offer to repurchase, prepay, defease or redeem such Indebtedness to be made, prior to its stated maturity, or such Guarantee to become payable or cash collateral in respect thereof to be demanded or; (ii) the Borrower or any Subsidiary fails in the performance or observance (beyond the applicable grace period with respect thereto, if any) of any Material Contract (other than those covered in clauses (i) and (iii) hereof) and such default together with any other such defaults, could reasonably be expected to have a Material Adverse Effect; or (iii) there occurs under any Swap Contract an Early Termination Date (as defined in such Swap Contract) resulting from (A) any event of default under such Swap Contract as to which the Borrower or any Subsidiary is the Defaulting Party (as defined in such Swap Contract) or (B) any Termination Event (as defined in such Swap Contract) under such Swap Contract as to which the Borrower or any Subsidiary is an Affected Party (as defined in such Swap Contract) and, in either event, the Swap Termination Value owed by the Borrower or such Subsidiary as a result thereof is greater than the Threshold Amount; or

(f) Insolvency Proceedings, Etc. The Borrower or any Subsidiaries (i) institutes or consents to the institution of any proceeding under any Debtor Relief Law, or makes an assignment for the benefit of creditors or (ii) applies for or consents to the appointment of any receiver, trustee, custodian, conservator, liquidator, rehabilitator or similar officer for it or for all or any material part of its property; or any receiver, trustee, custodian, conservator, liquidator, rehabilitator or similar officer is appointed without the application or consent of such Person and the appointment continues undischarged or unstayed for 60 calendar days; or any proceeding under any Debtor Relief Law relating to any such Person or to all or any material part of its property is instituted without the consent of such Person and continues undismissed or unstayed for 60 calendar days, or an order for relief is entered in any such proceeding; or

(g) Inability to Pay Debts; Attachment. (i) The Borrower or any Subsidiary admits in writing its inability or fails generally to pay its debts as they become due, or (ii) any writ or warrant of attachment or execution or similar process is issued or levied against all or any material part of the property of any such Person and is not released, vacated or fully bonded within 30 days after its issue or levy; or

(h) Judgments. There is entered against the Borrower or any Subsidiary (i) a final judgment or order for the payment of money in an aggregate amount exceeding the Threshold Amount (to the extent not covered by independent third-party insurance as to which the insurer does not dispute coverage), or (ii) any one or more non-monetary final judgments that

have, or could reasonably be expected to have, individually or in the aggregate, a Material Adverse Effect and, in either case, there is a period of 30 (thirty) consecutive days during which a stay of enforcement of such judgment, by reason of a pending appeal or otherwise, is not in effect; or

(i) ERISA. (i) An ERISA Event occurs with respect to a Pension Plan or Multiemployer Plan which has resulted or could reasonably be expected to result in liability of the Borrower or any Subsidiary under Title IV of ERISA to the Pension Plan, Multiemployer Plan or the PBGC in an aggregate amount in excess of the Threshold Amount, or (ii) the Borrower or any ERISA Affiliate fails to pay when due, after the expiration of any applicable grace period, any installment payment with respect to its withdrawal liability under Section 4201 of ERISA under a Multiemployer Plan in an aggregate amount in excess of the Threshold Amount; or

(j) Invalidity of Loan Documents. Any Loan Document, at any time after its execution and delivery and for any reason other than as expressly permitted hereunder or satisfaction in full of all the Obligations, ceases to be in full force and effect; or any Loan Party or any other Person contests in any manner the validity or enforceability of any Loan Document; or any Responsible Officer of a Loan Party denies that it has any or further liability or obligation under any Loan Document, or purports to revoke, terminate or rescind any Loan Document, or in the case of any Lien granted pursuant to any Collateral Document (including any Lien granted after the Closing Date in accordance with Section 6.13, 6.14 or 6.15) in favor of the Administrative Agent, such Lien ceases to have the priority purported to be granted under such Collateral Document (other than pursuant to the terms thereof or hereunder) or is declared by a court of competent jurisdiction to be null and void, invalid or unenforceable in any respect; or

(k) Subsidiary Guaranty. The Subsidiary Guaranty given by any Guarantor (including any Person that becomes a Guarantor after the Closing Date in accordance with Section 6.13) or any provision thereof shall cease to be in full force and effect, or any Responsible Officer of a Guarantor (including any Person that becomes a Guarantor after the Closing Date in accordance with Section 6.13) or any Person acting by or on behalf of such Guarantor shall deny or disaffirm such Guarantor's obligations under the Subsidiary Guaranty, or any Guarantor shall default in the due performance or observance of any term, covenant or agreement on its part to be performed or observed pursuant to the Subsidiary Guaranty; or

(l) Change of Control. There occurs any Change of Control with respect to the Borrower; or

(m) HMO Event. (i) An HMO Event shall remain unremedied for sixty (60) days after the occurrence thereof (or such lesser period of time, if any, as the HMO Regulator administering the HMO Regulations shall have imposed for the cure of such HMO Event), or (ii) any HMO Subsidiary shall suffer the loss of twenty-five percent (25%) or more of the enrolled recipients for which it is responsible as measured from the beginning of the previous month or from the close of its immediately preceding fiscal-year end and could reasonably be expected to have a Material Adverse Effect; or

(n) Exclusion Event. There shall occur an Exclusion Event that would result in a Material Adverse Effect.

Section 8.02 Remedies Upon Event of Default. If any Event of Default occurs and is continuing, the Administrative Agent shall, at the request of, or may, with the consent of, the Required Lenders, take any or all of the following actions:

(a) declare the Commitment of each Lender to be terminated, whereupon such Commitments and obligation shall be terminated;

(b) declare the unpaid principal amount of all outstanding Loans, all interest accrued and unpaid thereon, and all other amounts owing or payable hereunder or under any other Loan Document to be immediately due and payable, without presentment, demand, protest or other notice of any kind, all of which are hereby expressly waived by the Borrower;

(c) require that the Borrower Cash Collateralize the L/C Obligations (in an amount equal to the then Outstanding Amount thereof); and

(d) exercise on behalf of itself and the Lenders all rights and remedies available to it and the Lenders under applicable Law or the Loan Documents, including, without limitation, all rights and remedies existing under the Collateral Documents and all rights and remedies against a Guarantor;

provided, however, that upon the occurrence of an actual or deemed entry of an order for relief with respect to the Borrower under the Bankruptcy Code of the United States, the obligation of each Lender to make Loans and any obligation of the L/C Issuer to make L/C Credit Extensions shall automatically terminate, the unpaid principal amount of all outstanding Loans and all interest and other amounts as aforesaid shall automatically become due and payable, and the obligation of the Borrower to Cash Collateralize the L/C Obligations as aforesaid shall automatically become effective, in each case without further act of the Administrative Agent or any Lender.

Section 8.03 Application of Funds. After the exercise of remedies provided for in Section 8.02 (or after the Loans have automatically become immediately due and payable and the L/C Obligations have automatically been required to be Cash Collateralized as set forth in the proviso to Section 8.02), any amounts received on account of the Obligations shall be applied by the Administrative Agent in the following order:

First, to payment of that portion of the Obligations constituting fees, indemnities, expenses and other amounts (including Attorney Costs and amounts payable under Article III hereof and Section 2.5 of the Subsidiary Guaranty) payable to the Administrative Agent in its capacity as such;

Second, to payment of that portion of the Obligations constituting fees, indemnities and other amounts (other than principal and interest) payable to the Lenders (including Attorney Costs and amounts payable under Article III hereof and Section 2.5 of the Subsidiary Guaranty),

ratably among them in proportion to the amounts described in this clause Second payable to them;

Third, to payment of that portion of the Obligations constituting accrued and unpaid interest on the Loans and L/C Borrowings, ratably among the Lenders in proportion to the respective amounts described in this clause Third payable to them;

Fourth, (i) to payment of that portion of the Obligations constituting unpaid principal of the Loans and L/C Borrowings, ratably among the Lenders in proportion to the respective amounts described in this subclause (i) to this clause Fourth held by them and (ii) to payment of that portion of the Obligations constituting amounts owing under or in respect of Secured Swap Contracts, ratably among the Swap Banks in proportion to the respective amounts described in this subclause (ii) to this clause Fourth held by them;

Fifth, to the Administrative Agent for the account of the L/C Issuer, to Cash Collateralize that portion of L/C Obligations comprised of the aggregate undrawn amount of Letters of Credit; and

Last, the balance, if any, after all of the Obligations have been indefeasibly paid in full, to the Borrower or as otherwise required by applicable Law.

Subject to Section 2.03(c), amounts used to Cash Collateralize the aggregate undrawn amount of Letters of Credit pursuant to clause Fifth above shall be applied to satisfy drawings under such Letters of Credit as they occur. If any amount remains on deposit as Cash Collateral after all Letters of Credit have either been fully drawn or expired, such remaining amount shall be applied to the other Obligations, if any, in the order set forth above.

ARTICLE IX
ADMINISTRATIVE AGENT

Section 9.01 Appointment and Authorization of Administrative Agent.

(a) Each Lender hereby irrevocably appoints, designates and authorizes the Administrative Agent to take such action on its behalf under the provisions of this Agreement and each other Loan Document and to exercise such powers and perform such duties as are expressly delegated to it by the terms of this Agreement or any other Loan Document, together with such powers as are reasonably incidental thereto. Notwithstanding any provision to the contrary contained elsewhere herein or in any other Loan Document, neither the Administrative Agent nor any other Agent-Related Person shall have any duties or responsibilities, except those expressly set forth herein, nor shall the Administrative Agent and any other Agent-Related Persons have or be deemed to have any fiduciary relationship with any Lender or participant, and no implied covenants, functions, responsibilities, duties, obligations or liabilities shall be read into this Agreement or any other Loan Document or otherwise exist against the Administrative Agent and any other Agent-Related Persons. Without limiting the generality of the foregoing sentence, the use of the term "agent" herein and in the other Loan Documents with reference to the Administrative Agent is not intended to connote any fiduciary or other implied (or express) obligations arising under agency doctrine of any applicable Law. Instead, such term is used

merely as a matter of market custom, and is intended to create or reflect only an administrative relationship between independent contracting parties.

(b) The L/C Issuer shall act on behalf of the Lenders with respect to any Letters of Credit issued by it and the documents associated therewith, and the L/C Issuer shall have all of the benefits and immunities (i) provided to the Administrative Agent in this Article IX with respect to any acts taken or omissions suffered by the L/C Issuer in connection with Letters of Credit issued by it or proposed to be issued by it and the applications and agreements for letters of credit pertaining to such Letters of Credit as fully as if the term "Administrative Agent" as used in this Article IX and in the definition of "Agent-Related Person" included the L/C Issuer with respect to such acts or omissions, and (ii) as additionally provided herein with respect to the L/C Issuer.

Section 9.02 Delegation of Duties. The Administrative Agent may execute any of its duties under this Agreement or any other Loan Document by or through agents, employees or attorneys-in-fact and shall be entitled to advice of counsel and other consultants or experts concerning all matters pertaining to such duties. The Administrative Agent shall not be responsible for the negligence or misconduct of any agent or attorney-in-fact that it selects in the absence of gross negligence or willful misconduct.

Section 9.03 Liability of Agent-Related Persons. No Agent-Related Person shall (a) be liable for any action taken or omitted to be taken by any of them under or in connection with this Agreement or any other Loan Document or the transactions contemplated hereby (except for its own gross negligence or willful misconduct in connection with its duties expressly set forth herein), or (b) be responsible in any manner to any Lender or participant for any recital, statement, representation or warranty made by any Loan Party or any officer thereof, contained herein or in any other Loan Document, or in any certificate, report, statement or other document referred to or provided for in, or received by the Administrative Agent under or in connection with, this Agreement or any other Loan Document, or the validity, effectiveness, genuineness, enforceability or sufficiency of this Agreement or any other Loan Document, or for any failure of any Loan Party or any other party to any Loan Document to perform its obligations hereunder or thereunder. No Agent-Related Person shall be under any obligation to any Lender or participant to ascertain or to inquire as to the observance or performance of any of the agreements contained in, or conditions of, this Agreement or any other Loan Document, or to inspect the properties, books or records of any Loan Party or any Affiliate thereof.

Section 9.04 Reliance by Administrative Agent.

(a) The Administrative Agent shall be entitled to rely, and shall be fully protected in relying, upon any writing, communication, signature, resolution, representation, notice, consent, certificate, affidavit, letter, telegram, facsimile, telex or telephone message, electronic mail message, statement or other document or conversation believed by it to be genuine and correct and to have been signed, sent or made by the proper Person or Persons, and upon advice and statements of legal counsel (including counsel to any Loan Party), independent accountants and other experts selected by the Administrative Agent. The Administrative Agent shall be fully justified in failing or refusing to take any action under any Loan Document unless it shall first receive such advice or concurrence of the Required Lenders as it deems appropriate,

and, if it so requests, it shall first be indemnified to its satisfaction by the Lenders against any and all liability and expense which may be incurred by it by reason of taking or continuing to take any such action. The Administrative Agent shall in all cases be fully protected in acting, or in refraining from acting, under this Agreement or any other Loan Document in accordance with a request or consent of the Required Lenders (or such greater number of Lenders as may be expressly required hereby in any instance) and such request and any action taken or failure to act pursuant thereto shall be binding upon all the Lenders.

(b) For purposes of determining compliance with the conditions specified in Section 4.01, each Lender that has signed this Agreement shall be deemed to have consented to, approved or accepted or to be satisfied with, each document or other matter required thereunder to be consented to or approved by or acceptable or satisfactory to a Lender unless the Administrative Agent shall have received notice from such Lender prior to the proposed Closing Date specifying its objection thereto.

Section 9.05 Notice of Default. The Administrative Agent shall not be deemed to have knowledge or notice of the occurrence of any Default, except with respect to defaults in the payment of principal, interest and fees required to be paid to the Administrative Agent for the account of the Lenders, unless the Administrative Agent shall have received written notice from a Lender or the Borrower referring to this Agreement, describing such Default and stating that such notice is a "notice of default." The Administrative Agent will notify the Lenders of its receipt of any such notice. The Administrative Agent shall take such action with respect to such Default as may be directed by the Required Lenders in accordance with Article VIII; provided, however, that unless and until the Administrative Agent has received any such direction, the Administrative Agent may (but shall not be obligated to) take such action, or refrain from taking such action, with respect to such Default as it shall deem advisable or in the best interest of the Lenders.

Section 9.06 Credit Decision; Disclosure of Information by Administrative Agent. Each Lender acknowledges that no Agent-Related Person has made any representation or warranty to it, and that no act by the Administrative Agent hereafter taken, including any consent to and acceptance of any assignment or review of the affairs of any Loan Party or any Affiliate thereof, shall be deemed to constitute any representation or warranty by any Agent-Related Person to any Lender as to any matter, including whether Agent-Related Persons have disclosed material information in their possession. Each Lender represents to the Administrative Agent that it has, independently and without reliance upon any Agent-Related Person and based on such documents and information as it has deemed appropriate, made its own appraisal of and investigation into the business, prospects, operations, property, financial and other

condition and creditworthiness of the Loan Parties and their respective Subsidiaries, and all applicable bank or other regulatory Laws relating to the transactions contemplated hereby, and made its own decision to enter into this Agreement and to extend credit to the Borrower. Each Lender also represents that it will, independently and without reliance upon any Agent-Related Person and based on such documents and information as it shall deem appropriate at the time, continue to make its own credit analysis, appraisals and decisions in taking or not taking action under this Agreement and the other Loan Documents, and to make such investigations as it deems necessary to inform itself as to the business, prospects, operations, property, financial and other condition and creditworthiness of the Borrower. Except for notices, reports and other documents expressly required to be furnished to the Lenders by the Administrative Agent herein, the Administrative Agent shall not have any duty or responsibility to provide any Lender with any credit or other information concerning the business, prospects, operations, property, financial and other condition or creditworthiness of any of the Loan Parties or any of their respective Affiliates which may come into the possession of any Agent-Related Person.

Section 9.07 Indemnification of Administrative Agent. Whether or not the transactions contemplated hereby are consummated, the Lenders shall indemnify upon demand each Agent-Related Person (to the extent not reimbursed by or on behalf of the Borrower or any Guarantor and without limiting the obligation of the Borrower or any Guarantor to do so), pro rata, and hold harmless each Agent-Related Person from and against any and all Indemnified Liabilities incurred by it; provided, however, that no Lender shall be liable for the payment to any Agent-Related Person of any portion of such Indemnified Liabilities to the extent determined in a final, nonappealable judgment by a court of competent jurisdiction to have resulted from such Agent-Related Person's own gross negligence or willful misconduct; provided, however, that no action taken in accordance with the directions of the Required Lenders shall be deemed to constitute gross negligence or willful misconduct for purposes of this Section 9.07. In the case of any investigation, litigation or proceeding giving rise to Indemnified Liabilities, this Section 9.07 applies whether any such investigation, litigation or proceeding is brought by any Lender or any other Person. Without limitation of the foregoing, each Lender shall reimburse the Administrative Agent upon demand for its ratable share of any costs or out-of-pocket expenses (including Attorney Costs) incurred by the Administrative Agent in connection with the preparation, execution, delivery, administration, modification, amendment or enforcement (whether through negotiations, legal proceedings or otherwise) of, or legal advice in respect of rights or responsibilities under, this Agreement, any other Loan Document, or any document contemplated by or referred to herein, to the extent that the Administrative Agent is not reimbursed for such expenses by or on behalf of the Borrower. The undertaking in this Section shall survive termination of the Aggregate Commitments, the payment of all other Obligations and the resignation of the Administrative Agent.

Section 9.08 Administrative Agent in its Individual Capacity. Bank of America and its Affiliates may make loans to, issue letters of credit for the account of, accept deposits from, acquire equity interests in and generally engage in any kind of banking, trust, financial advisory, underwriting or other business with each of the Loan Parties and their respective Affiliates as though Bank of America were not the Administrative Agent or the L/C Issuer hereunder and without notice to or consent of the Lenders. The Lenders acknowledge that, pursuant to such activities, Bank of America or its Affiliates may receive information regarding any Loan Party or its Affiliates (including information that may be subject to confidentiality obligations in favor of such Loan Party or such Affiliate) and acknowledge that the Administrative Agent shall be under no obligation to provide such information to them. With respect to its Loans, Bank of America shall have the same rights and powers under this Agreement as any other Lender and may exercise such rights and powers as though it were not the Administrative Agent or the L/C Issuer, and the terms "Lender" and "Lenders" include Bank of America in its individual capacity.

Section 9.09 Successor Administrative Agent. The Administrative Agent may resign as Administrative Agent upon 30 days' notice to the Lenders and the Borrower; provided that any such resignation by Bank of America shall also constitute its resignation as L/C Issuer. If the Administrative Agent resigns under this Agreement, the Required Lenders shall appoint from among the Lenders a successor administrative agent for the Lenders, which successor administrative agent shall be consented to by the Borrower at all times other than during the existence of an Event of Default (which consent of the Borrower shall not be unreasonably withheld or delayed). If no successor administrative agent is appointed prior to the effective date of the resignation of the Administrative Agent, the Administrative Agent may appoint, after consulting with the Lenders and the Borrower, a successor administrative agent from among the Lenders. Upon the acceptance of its appointment as successor administrative agent hereunder, the Person acting as such successor administrative agent shall succeed to all the rights, powers and duties of the retiring Administrative Agent and L/C Issuer and the respective terms "Administrative Agent" and "L/C Issuer" shall mean such successor administrative agent and Letter of Credit issuer and the retiring Administrative Agent's appointment, powers and duties as Administrative Agent shall be terminated and the retiring L/C Issuer's rights, powers and duties as such shall be terminated, without any other or further act or deed on the part of such retiring L/C Issuer or any other Lender, other than the obligation of the successor L/C Issuer to issue letters of credit in substitution for the Letters of Credit, if any, existing at the time of such succession or to make other arrangements satisfactory to the retiring L/C Issuer to effectively assume the obligations of the retiring L/C Issuer with respect to such Letters of Credit. After any retiring Administrative Agent's resignation hereunder as Administrative Agent, the provisions of this Article IX and Sections 10.04 and 10.05 shall inure to its benefit as to any actions taken or omitted to be taken by it while it was Administrative Agent under this Agreement. If no successor administrative agent has accepted appointment as Administrative Agent by the date which is 30 days following a retiring Administrative Agent's notice of resignation, the retiring Administrative Agent's resignation shall nevertheless thereupon become effective and the Lenders shall perform all of the duties of the Administrative Agent hereunder until such time, if any, as the Required Lenders appoint a successor agent as provided for above.

Section 9.10 Administrative Agent May File Proofs of Claim. In case of the pendency of any receivership, insolvency, liquidation, bankruptcy, reorganization, arrangement, adjustment, composition or other judicial proceeding relative to any Loan Party, the Administrative Agent (irrespective of whether the principal of any Loan or L/C Obligation shall then be due and payable as herein expressed or by declaration or otherwise and irrespective of whether the Administrative Agent shall have made any demand on the Borrower) shall be entitled and empowered, by intervention in such proceeding or otherwise:

(a) to file and prove a claim for the whole amount of the principal and interest owing and unpaid in respect of the Loans, L/C Obligations and all other Obligations that are owing and unpaid and to file such other documents as may be necessary or advisable in order to have the claims of the Lenders and the Administrative Agent (including any claim for the reasonable compensation, expenses, disbursements and advances of the Lenders and the Administrative Agent and their respective agents and counsel and all other amounts due the Lenders and the Administrative Agent under Sections 2.03(i) and (j), 2.09 and 10.04) allowed in such judicial proceeding; and

(b) to collect and receive any monies or other property payable or deliverable on any such claims and to distribute the same;

and any custodian, receiver, assignee, trustee, liquidator, sequestrator or other similar official in any such judicial proceeding is hereby authorized by each Lender to make such payments to the Administrative Agent and, in the event that the Administrative Agent shall consent to the making of such payments directly to the Lenders, to pay to the Administrative Agent any amount due for the reasonable compensation, expenses, disbursements and advances of the Administrative Agent and its agents and counsel, and any other amounts due the Administrative Agent under Sections 2.09 and 10.04.

Nothing contained herein shall be deemed to authorize the Administrative Agent to authorize or consent to or accept or adopt on behalf of any Lender any plan of reorganization, arrangement, adjustment or composition affecting the Obligations or the rights of any Lender or to authorize the Administrative Agent to vote in respect of the claim of any Lender in any such proceeding.

Section 9.11 Collateral and Guaranty Matters. The Lenders irrevocably authorize the Administrative Agent, at its option and in its discretion,

(a) to release any Lien on any property granted to or held by the Administrative Agent under any Loan Document (i) upon termination of the Aggregate Commitments and payment in full of all Obligations (other than contingent indemnification obligations) and the expiration or termination of all Letters of Credit, (ii) that is sold or to be sold as part of or in connection with any sale permitted hereunder or under any other Loan Document, or (iii) subject to Section 10.01, if approved, authorized or ratified in writing by the Required Lenders;

(b) to subordinate any Lien on any property granted to or held by the Administrative Agent under any Loan Document to the holder of any Lien on such property that is permitted by Section 7.01(h); and

(c) to release any Guarantor from its obligations under the Subsidiary Guaranty if such Person ceases to be a Subsidiary as a result of a transaction permitted hereunder.

Upon request by the Administrative Agent at any time, the Required Lenders will confirm in writing the Administrative Agent's authority to release or subordinate its interest in particular types or items of property, or to release any Guarantor from its obligations under the Subsidiary Guaranty pursuant to this Section 9.11.

Section 9.12 Other Agents; Arrangers and Managers. None of the Lenders or other Persons identified on the facing page or signature pages of this Agreement as a "syndication agent," "documentation agent," "co-agent," "book manager," "book runner," "lead manager," "arranger," "lead arranger," "co-lead arranger" or "co-arranger" shall have any right, power, obligation, liability, responsibility or duty under this Agreement other than, in the case of such Lenders, those applicable to all Lenders as such. Without limiting the foregoing, none of the

Lenders or other Persons so identified shall have or be deemed to have any fiduciary relationship with any Lender. Each Lender acknowledges that it has not relied, and will not rely, on any of the Lenders or other Persons so identified in deciding to enter into this Agreement or in taking or not taking action hereunder.

ARTICLE X
MISCELLANEOUS

Section 10.01 Amendments, Etc. No amendment or waiver of any provision of this Agreement or any other Loan Document, and no consent to any departure by the Borrower or any other Loan Party therefrom, shall in any event be effective unless the same shall be in writing and signed by the Required Lenders and the Borrower or the applicable Loan Party, as the case may be, and acknowledged by the Administrative Agent, then each such waiver or consent shall be effective only in the specific instance and for the specific purpose for which given; provided, however, that no such amendment, waiver or consent shall:

(a) waive any condition set forth in Section 4.01(a) without the written consent of each Lender;

(b) extend or increase the Commitment of any Lender (or reinstate any Commitment terminated pursuant to Section 8.02) without the written consent of such Lender;

(c) postpone any date fixed by this Agreement or any other Loan Document for any payment of principal, interest, fees or other amounts due to the Lenders (or any of them) or any scheduled or mandatory reduction of the Aggregate Commitments hereunder or under any other Loan Document without the written consent of each Lender directly affected thereby;

(d) reduce the principal of, or the rate of interest specified herein on, any Loan or L/C Borrowing, or (subject to clause (iii) of the second proviso to this Section 10.01) any fees or other amounts payable hereunder or under any other Loan Document without the written consent of each Lender directly affected thereby; provided, however, that only the consent of the Required Lenders shall be necessary (i) to amend the definition of "Default Rate" or to waive any obligation of the Borrower to pay interest at the Default Rate or (ii) to amend any financial covenant hereunder (or any defined term used therein) even if the effect of such amendment would be to reduce the rate of interest on any Loan or L/C Borrowing or to reduce any fee payable hereunder;

(e) change Section 2.13 or Section 8.03 in a manner that would alter the pro rata sharing of payments required thereby without the written consent of each Lender;

(f) change any provision of this Section or the definition of "Required Lenders" or any other provision hereof specifying the number or percentage of Lenders required to amend, waive or otherwise modify any rights hereunder or make any determination or grant any consent hereunder, without the written consent of each Lender; or

(g) release all or substantially all of the Guarantors from the Subsidiary Guaranty without the written consent of each Lender, or release all or substantially all of the

Collateral except as specifically permitted by the Loan Documents without the written consent of each Lender;

provided further, that (i) no amendment, waiver or consent shall, unless in writing and signed by the L/C Issuer in addition to the Lenders required above, affect the rights or duties of the L/C Issuer under this Agreement or any Letter of Credit Application relating to any Letter of Credit issued or to be issued by it, (ii) no amendment, waiver or consent shall, unless in writing and signed by the Administrative Agent in addition to the Lenders required above, affect the rights or duties of the Administrative Agent under this Agreement or any other Loan Document, and (iii) each of the Fee Letter and the Commitment Letter may be amended, or rights or privileges thereunder waived, in a writing executed only by the parties thereto. Notwithstanding anything to the contrary herein, no Defaulting Lender shall have any right to approve or disapprove any amendment, waiver or consent hereunder, except that the Commitment of such Lender may not be increased or extended without the consent of such Lender. Upon delivery by the Borrower of each Compliance Certificate of Responsible Officers certifying supplements to the Schedules to this Agreement pursuant to Section 6.02(b), the schedule supplements attached to each such certificate shall be incorporated into and become a part of and supplement Schedules 5.08, 5.11, 5.20, 5.24 and 6.07 hereto, as applicable, and the Administrative Agent may attach such schedule supplements to such Schedules, and each reference to such Schedules shall mean and be a reference to such Schedules, as supplemented pursuant thereto.

Section 10.02 Notices and Other Communications; Facsimile Copies.

(a) General. Unless otherwise expressly provided herein, all notices and other communications provided for hereunder shall be in writing (including by facsimile transmission). All such written notices shall be mailed, faxed or delivered to the applicable address, facsimile number or (subject to subsection (c) below) electronic mail address, and all notices and other communications expressly permitted hereunder to be given by telephone shall be made to the applicable telephone number, as follows:

(i) if to the Borrower, the Administrative Agent or the L/C Issuer, to the address, facsimile number, electronic mail address or telephone number specified for such Person on Schedule 10.02 or to such other address, facsimile number, electronic mail address or telephone number as shall be designated by such party in a notice to the other parties hereto; and

(ii) if to any other Lender, to the address, facsimile number, electronic mail address or telephone number specified in its Administrative Questionnaire or to such other address, facsimile number, electronic mail address or telephone number as shall be designated by such party in a notice to the Borrower, the Administrative Agent and the L/C Issuer.

All such notices and other communications shall be deemed to be given or made upon the earlier to occur of (i) actual receipt by the relevant party hereto and (ii) (A) if delivered by hand or by courier, when signed for by or on behalf of the relevant party hereto; (B) if delivered by mail, four Business Days after deposit in the mails, postage prepaid; (C) if delivered by facsimile, when sent and receipt has been confirmed by telephone; and (D) if delivered by electronic mail

(which form of delivery is subject to the provisions of subsection (c) below), when delivered; provided, however, that notices and other communications to the Administrative Agent and the L/C Issuer pursuant to Article II shall not be effective until actually received by such Person. In no event shall a voicemail message be effective as a notice, communication or confirmation hereunder.

(b) Effectiveness of Facsimile Documents and Signatures. Loan Documents may be transmitted and/or signed by facsimile. The effectiveness of any such documents and signatures shall, subject to applicable Law, have the same force and effect as manually-signed originals and shall be binding on all Loan Parties, the Administrative Agent, the Syndication Agent, the L/C Issuer, the Co-Lead Arrangers and the Lenders. The Administrative Agent may also require that any such documents and signatures be confirmed by a manually-signed original thereof; provided, however, that the failure to request or deliver the same shall not limit the effectiveness of any facsimile document or signature.

(c) Limited Use of Electronic Mail. Electronic mail and Internet and intranet websites may be used only to distribute routine communications, such as financial statements and other information as provided in Section 6.02, and to distribute Loan Documents for execution by the parties thereto, and may not be used for any other purpose.

(d) Reliance by Administrative Agent and Lenders. The Administrative Agent and the Lenders shall be entitled to rely and act upon any notices (including written or telephonic Loan Notices) purportedly given by or on behalf of the Borrower even if (i) such notices were not made in a manner specified herein, were incomplete or were not preceded or followed by any other form of notice specified herein, or (ii) the terms thereof, as understood by the recipient, varied from any confirmation thereof. The Borrower shall indemnify each Agent-Related Person and each Lender from all losses, costs, expenses and liabilities resulting from the reliance by such Person on each notice purportedly given by or on behalf of the Borrower. All telephonic notices to and other communications with the Administrative Agent may be recorded by the Administrative Agent, and each of the parties hereto hereby consents to such recording.

Section 10.03 No Waiver; Cumulative Remedies. No failure by any Lender or the Administrative Agent to exercise, and no delay by any such Person in exercising, any right, remedy, power or privilege hereunder shall operate as a waiver thereof; nor shall any single or partial exercise of any right, remedy, power or privilege hereunder preclude any other or further exercise thereof or the exercise of any other right, remedy, power or privilege. The rights, remedies, powers and privileges herein provided are cumulative and not exclusive of any rights, remedies, powers and privileges provided by Law.

Section 10.04 Attorney Costs, Expenses and Taxes. The Borrower agrees (a) to pay or reimburse the Administrative Agent and the Co-Lead Arrangers for all reasonable costs and expenses incurred in connection with the development, preparation, negotiation and execution of the Commitment Letter, the Fee Letter, this Agreement and the other Loan Documents, the due diligence related thereto, and the syndication of the Loans, and any amendment, waiver, consent or other modification of the provisions hereof and thereof (whether or not the transactions contemplated hereby or thereby are consummated), and the consummation and administration of the transactions contemplated hereby and thereby, including all Attorney Costs, and (b) to pay or

reimburse the Administrative Agent and each Lender for all reasonable costs and expenses incurred in connection with the enforcement, attempted enforcement, or preservation of any rights or remedies under this Agreement or the other Loan Documents (including all such costs and expenses incurred during any "workout" or restructuring in respect of the Obligations and during any legal proceeding, including any proceeding under any Debtor Relief Law), including all Attorney Costs. The foregoing costs and expenses shall include all search, filing, recording, title insurance and appraisal charges and fees and taxes related thereto, and other out-of-pocket expenses incurred by the Administrative Agent and the cost of independent public accountants and other outside experts retained by the Administrative Agent or any Lender. All amounts due under this Section 10.04 shall be payable within ten Business Days after demand therefor. The agreements in this Section shall survive the termination of the Aggregate Commitments and repayment of all other Obligations.

Section 10.05 Indemnification by the Borrower. Whether or not the transactions contemplated hereby are consummated, the Borrower shall indemnify and hold harmless each Agent-Related Person, each Co-Lead Arranger, the Syndication Agent, each Lender and their respective Affiliates, directors, officers, employees, counsel, agents and attorneys-in-fact (collectively the "Indemnitees") from and against any and all liabilities, obligations, losses, damages, penalties, claims, demands, actions, judgments, suits, costs, expenses and disbursements (including Attorney Costs) of any kind or nature whatsoever which may at any time be imposed on, incurred by or asserted against any such Indemnitee in any way relating to or arising out of or in connection with (a) the Commitment Letter (including, without limitation, the pre-closing syndication and arrangement of the Loans), (b) the execution, delivery, enforcement, performance or administration of any Loan Document or any other agreement, letter or instrument delivered in connection with the transactions contemplated thereby or the consummation of the transactions contemplated thereby, (c) any Commitment, Loan or Letter of Credit or the use or proposed use of the proceeds therefrom (including any refusal by the L/C Issuer to honor a demand for payment under a Letter of Credit if the documents presented in connection with such demand do not strictly comply with the terms of such Letter of Credit), (d) any actual or alleged presence or release of Hazardous Materials on or from any property currently or formerly owned or operated by the Borrower, any other Loan Party or any of their respective Subsidiaries, or any Environmental Liability related in any way to the Borrower, any other Loan Party or any of their respective Subsidiaries, or (e) any actual or prospective claim, litigation, investigation or proceeding relating to any of the foregoing, whether based on contract, tort or any other theory (including any investigation of, preparation for, or defense of any pending or threatened claim, investigation, litigation or proceeding) and regardless of whether any Indemnitee is a party thereto (all the foregoing, collectively, the "Indemnified Liabilities"), in all cases, whether or not caused by or arising, in whole or in part, out of the negligence of the Indemnitee; provided that such indemnity shall not, as to any Indemnitee, be available to the extent that such liabilities, obligations, losses, damages, penalties, claims, demands, actions, judgments, suits, costs, expenses or disbursements are determined by a court of competent jurisdiction by final and nonappealable judgment to have resulted from the gross negligence or willful misconduct of such Indemnitee. No Indemnitee shall be liable for any damages arising from the use by others of any information or other materials obtained through IntraLinks or other similar information transmission systems in connection with this Agreement, nor shall any Indemnitee have any liability for any indirect or consequential damages relating to this

Agreement or any other Loan Document or arising out of its activities in connection herewith or therewith (whether before or after the Closing Date). In the case of an investigation, litigation or proceeding to which the indemnity in this Section 10.05 applies, such indemnity shall be effective whether or not such investigation, litigation or proceeding is brought by the Borrower or any of the Subsidiaries, its directors, stockholders or auditors or an Indemnitee or any other Person, whether or not any Indemnitee is otherwise a party thereto. All amounts due under this Section 10.05 shall be payable within ten Business Days after demand therefor. The agreements in this Section shall survive the resignation of the Administrative Agent, the replacement of any Lender, the termination of the Aggregate Commitments and the repayment, satisfaction or discharge of all the other Obligations.

Section 10.06 Payments Set Aside. To the extent that any payment by or on behalf of the Borrower is made to the Administrative Agent or any Lender, or the Administrative Agent or any Lender exercises its right of set-off, and such payment or the proceeds of such set-off or any part thereof is subsequently invalidated, declared to be fraudulent or preferential, set aside or required (including pursuant to any settlement entered into by the Administrative Agent or such Lender in its discretion) to be repaid to a trustee, receiver or any other party, in connection with any proceeding under any Debtor Relief Law or otherwise, then (a) to the extent of such recovery, the obligation or part thereof originally intended to be satisfied shall be revived and continued in full force and effect as if such payment had not been made or such set-off had not occurred, and (b) each Lender severally agrees to pay to the Administrative Agent upon demand its applicable share of any amount so recovered from or repaid by the Administrative Agent, plus interest thereon from the date of such demand to the date such payment is made at a rate per annum equal to the Federal Funds Rate from time to time in effect.

Section 10.07 Successors and Assigns.

(a) The provisions of this Agreement shall be binding upon and inure to the benefit of the parties hereto and their respective successors and assigns permitted hereby, except that the Borrower may not assign or otherwise transfer any of its rights or obligations hereunder without the prior written consent of each Lender and no Lender may assign or otherwise transfer any of its rights or obligations hereunder except (i) to an Eligible Assignee in accordance with the provisions of subsection (b) of this Section, (ii) by way of participation in accordance with the provisions of subsection (d) of this Section, or (iii) by way of pledge or assignment of a security interest subject to the restrictions of subsection (f) of this Section (and any other attempted assignment or transfer by any party hereto shall be null and void). Nothing in this Agreement, expressed or implied, shall be construed to confer upon any Person (other than the parties hereto, their respective successors and assigns permitted hereby, Participants to the extent provided in subsection (d) of this Section and, to the extent expressly contemplated hereby, the Indemnitees) any legal or equitable right, remedy or claim under or by reason of this Agreement.

(b) Any Lender may at any time assign to one or more Eligible Assignees all or a portion of its rights and obligations under this Agreement (including all or a portion of its Commitment and the Loans (including for purposes of this subsection (b), participations in L/C Obligations) at the time owing to it); provided that (i) except in the case of an assignment of the entire remaining amount of the assigning Lender's Commitment and the Loans at the time owing to it or in the case of an assignment to a Lender or an Affiliate of a Lender or an Approved Fund

with respect to a Lender, the aggregate amount of the Commitment (which for this purpose includes Loans outstanding thereunder) subject to each such assignment, determined as of the date the Assignment and Assumption with respect to such assignment is delivered to the Administrative Agent or, if "Trade Date" is specified in the Assignment and Assumption, as of the Trade Date, shall not be less than $1 million unless each of the Administrative Agent and, so long as no Event of Default has occurred and is continuing, the Borrower otherwise consents (each such consent not to be unreasonably withheld or delayed), (ii) each partial assignment shall be made as an assignment of a proportionate part of all the assigning Lender's rights and obligations under this Agreement with respect to the Loans or the Commitment assigned, (iii) any assignment of a Commitment must be approved by the Administrative Agent and the L/C Issuer unless the Person that is the proposed assignee is itself a Lender (whether or not the proposed assignee would otherwise qualify as an Eligible Assignee), and (iv) the parties to each assignment shall execute and deliver to the Administrative Agent an Assignment and Assumption, together with a processing and recordation fee of $3,500. Subject to acceptance and recording thereof by the Administrative Agent pursuant to subsection (c) of this Section, from and after the effective date specified in each Assignment and Assumption, the Eligible Assignee thereunder shall be a party to this Agreement and, to the extent of the interest assigned by such Assignment and Assumption, have the rights and obligations of a Lender under this Agreement, and the assigning Lender thereunder shall, to the extent of the interest assigned by such Assignment and Assumption, be released from its obligations under this Agreement (and, in the case of an Assignment and Assumption covering all of the assigning Lender's rights and obligations under this Agreement, such Lender shall cease to be a party hereto but shall continue to be entitled to the benefits of Sections 3.01, 3.04, 3.05, 10.04 and 10.05 with respect to facts and circumstances occurring prior to the effective date of such assignment). Upon request, the Borrower (at the expense of the assignee or assignor Lender) shall execute and deliver a Note to the assignee Lender. Any assignment or transfer by a Lender of rights or obligations under this Agreement that does not comply with this subsection shall be treated for purposes of this Agreement as a sale by such Lender of a participation in such rights and obligations in accordance with subsection (d) of this Section.

(c) The Administrative Agent, acting solely for this purpose as an agent of the Borrower, shall maintain at the Administrative Agent's Office a copy of each Assignment and Assumption delivered to it and a register for the recordation of the names and addresses of the Lenders, and the Commitments of, and principal amounts of the Loans and L/C Obligations owing to, each Lender pursuant to the terms hereof from time to time (the "Register"). The entries in the Register shall be conclusive, and the Borrower, the Administrative Agent and the Lenders may treat each Person whose name is recorded in the Register pursuant to the terms hereof as a Lender hereunder for all purposes of this Agreement, notwithstanding notice to the contrary. The Register shall be available for inspection by the Borrower and any Lender at any reasonable time and from time to time upon reasonable prior notice.

(d) Any Lender may at any time, without the consent of, or notice to, the Borrower or the Administrative Agent, sell participations to any Person (other than a natural person or the Borrower or any of the Borrower's Affiliates or Subsidiaries) (each, a "Participant") in all or a portion of such Lender's rights and/or obligations under this Agreement (including all or a portion of its Commitment and/or the Loans (including such Lender's

participations in L/C Obligations) owing to it); provided, further, that (i) such Lender's obligations under this Agreement shall remain unchanged, (ii) such Lender shall remain solely responsible to the other parties hereto for the performance of such obligations and (iii) the Borrower, the Administrative Agent and the other Lenders shall continue to deal solely and directly with such Lender in connection with such Lender's rights and obligations under this Agreement. Any agreement or instrument pursuant to which a Lender sells such a participation shall provide that such Lender shall retain the sole right to enforce this Agreement and to approve any amendment, modification or waiver of any provision of this Agreement; provided that such agreement or instrument may provide that such Lender will not, without the consent of the Participant, agree to any amendment, waiver or other modification described in the first proviso to Section 10.01 that directly affects such Participant. Subject to subsection (e) of this Section, the Borrower agrees that each Participant shall be entitled to the benefits of Sections 3.01, 3.04 and 3.05 to the same extent as if it were a Lender and had acquired its interest by assignment pursuant to subsection (b) of this Section. To the extent permitted by Law, each Participant also shall be entitled to the benefits of Section 10.09 as though it were a Lender; provided such Participant agrees to be subject to Section 2.13 as though it were a Lender.

(e) A Participant shall not be entitled to receive any greater payment under Section 3.01 or 3.04 than the applicable Lender would have been entitled to receive with respect to the participation sold to such Participant, unless the sale of the participation to such Participant is made with the Borrower's prior written consent. A Participant that would be a Foreign Lender if it were a Lender shall not be entitled to the benefits of Section 3.01 unless the Borrower is notified of the participation sold to such Participant and such Participant agrees, for the benefit of the Borrower, to comply with Section 10.15 as though it were a Lender.

(f) Any Lender may at any time pledge or assign a security interest in all or any portion of its rights under this Agreement (including under its Note, if any) to secure obligations of such Lender, including any pledge or assignment to secure obligations to a Federal Reserve Bank; provided that no such pledge or assignment shall release such Lender from any of its obligations hereunder or substitute any such pledgee or assignee for such Lender as a party hereto.

(g) As used herein, the following terms have the following meanings:

"Eligible Assignee" means (i) a Lender, (ii) an Affiliate of a Lender, (iii) an Approved Fund, and (iv) any other Person (other than a natural person) approved by (A) the Administrative Agent and the L/C Issuer, and (B) unless an Event of Default has occurred and is continuing, the Borrower (each such approval not to be unreasonably withheld or delayed); provided that notwithstanding the foregoing, "Eligible Assignee" shall not include the Borrower or any of the Borrower's Affiliates or Subsidiaries.

"Fund" means any Person (other than a natural person) that is (or will be) engaged in making, purchasing, holding or otherwise investing in commercial loans and similar extensions of credit in the ordinary course of its business.

"Approved Fund" means any Fund that is administered or managed by (i) a Lender, (ii) an Affiliate of a Lender or (iii) an entity or an Affiliate of an entity that administers or manages a Lender.

(h) Notwithstanding anything to the contrary contained herein, if at any time Bank of America assigns all of its Commitment and Loans pursuant to subsection (b) above, Bank of America may, upon 30 days notice to the Borrower and the Lenders, resign as L/C Issuer. In the event of any such resignation as L/C Issuer, the Borrower shall be entitled to appoint from among the Lenders a successor L/C Issuer hereunder; provided, however, that no failure by the Borrower to appoint any such successor shall affect the resignation of Bank of America as L/C Issuer. If Bank of America resigns as L/C Issuer, it shall retain all the rights and obligations of the L/C Issuer hereunder with respect to all Letters of Credit outstanding as of the effective date of its resignation as L/C Issuer and all L/C Obligations with respect thereto (including the right to require the Lenders to make Base Rate Loans or fund risk participations in Unreimbursed Amounts pursuant to Section 2.03(c)).

Section 10.08 Confidentiality. Each of the Administrative Agent, the L/C Issuer, the Syndication Agent and the Lenders agrees to maintain the confidentiality of the Information (as defined below), except that Information may be disclosed (a) to its and its Affiliates' directors, officers, employees and agents, including accountants, legal counsel and other advisors (it being understood that the Persons to whom such disclosure is made will be informed of the confidential nature of such Information and instructed to keep such Information confidential), (b) to the extent requested by any Governmental Authority, (c) to the extent required by applicable Law or by any subpoena or similar legal process, (d) to any other party to this Agreement, (e) in connection with the exercise of any remedies hereunder or any suit, action or proceeding relating to this Agreement or the enforcement of rights hereunder, (f) subject to an agreement containing provisions substantially the same as those of this Section, to (i) any Eligible Assignee of or Participant in, or any prospective Eligible Assignee of or Participant in, any of its rights or obligations under this Agreement or (ii) any direct or indirect contractual counterparty or prospective counterparty (or such contractual counterparty's or prospective counterparty's professional advisor) to any credit derivative transaction relating to obligations of the Loan Parties, (g) with the consent of the Borrower, (h) to the extent such Information (i) becomes publicly available other than as a result of a breach of this Section or (ii) becomes available to the Administrative Agent, the Syndication Agent or any Lender on a nonconfidential basis from a source other than the Borrower, or (i) to the NAIC or any other similar organization. In addition, the Administrative Agent, the Syndication Agent and the Lenders may disclose the existence of this Agreement and information about this Agreement to market data collectors, similar service providers to the lending industry, and service providers to the Administrative Agent, the Syndication Agent and the Lenders in connection with the administration and management of this Agreement, the other Loan Documents, the Commitments, and the Credit Extensions. For the purposes of this Section, "Information" means all information received from any Loan Party, relating to any Loan Party, its respective Subsidiaries or the business, other than any such information that is available to the Administrative Agent, the Syndication Agent or any Lender on a nonconfidential basis prior to disclosure by any Loan Party; provided that, in the case of information received from a Loan Party after the date hereof, such information is clearly identified in writing at the time of delivery as confidential. Any Person required to maintain the

confidentiality of Information as provided in this Section shall be considered to have complied with its obligation to do so if such Person has exercised the same degree of care to maintain the confidentiality of such Information as such Person would accord to its own confidential information.

Section 10.09 Set-off. In addition to any rights and remedies of the Lenders provided by Law, upon the occurrence and during the continuance of any Event of Default, each Lender is authorized at any time and from time to time, without prior notice to the Borrower or any other Loan Party, any such notice being waived by the Borrower (on its own behalf and on behalf of each Loan Party) to the fullest extent permitted by Law, to set off and apply any and all deposits (general or special, time or demand, provisional or final) at any time held by, and other indebtedness at any time owing by, such Lender to or for the credit or the account of the respective Loan Parties against any and all Obligations owing to such Lender hereunder or under any other Loan Document, now or hereafter existing, irrespective of whether or not the Administrative Agent or such Lender shall have made demand under this Agreement or any other Loan Document and although such Obligations may be contingent or unmatured. Each Lender agrees promptly to notify the Borrower and the Administrative Agent after any such set-off and application made by such Lender; provided, however, that the failure to give such notice shall not affect the validity of such set-off and application.

Section 10.10 Interest Rate Limitation. Notwithstanding anything to the contrary contained in any Loan Document, the interest paid or agreed to be paid under the Loan Documents shall not exceed the maximum rate of non-usurious interest permitted by applicable Law (the "Maximum Rate"). If the Administrative Agent or any Lender shall receive interest in an amount that exceeds the Maximum Rate, the excess interest shall be applied to the principal of the Loans or, if it exceeds such unpaid principal, refunded to the Borrower. In determining whether the interest contracted for, charged, or received by the Administrative Agent or a Lender exceeds the Maximum Rate, such Person may, to the extent permitted by applicable Law, (a) characterize any payment that is not principal as an expense, fee, or premium rather than interest, (b) exclude voluntary prepayments and the effects thereof, and (c) amortize, prorate, allocate, and spread in equal or unequal parts the total amount of interest throughout the contemplated term of the Obligations hereunder.

Section 10.11 Counterparts. This Agreement may be executed in one or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument.

Section 10.12 Integration. This Agreement, together with the other Loan Documents, comprises the complete and integrated agreement of the parties on the subject matter hereof and thereof and supersedes all prior agreements, written or oral, on such subject matter. In the event of any conflict between the provisions of this Agreement and those of any other Loan Document, the provisions of this Agreement shall control; provided that the inclusion of supplemental rights or remedies in favor of the Administrative Agent or the Lenders in any other Loan Document shall not be deemed a conflict with this Agreement. Each Loan Document was drafted with the joint participation of the respective parties thereto and shall be construed neither against nor in favor of any party, but rather in accordance with the fair meaning thereof.

Section 10.13 Survival of Representations and Warranties. All representations and warranties made hereunder and in any other Loan Document or other document delivered pursuant hereto or thereto or in connection herewith or therewith shall survive the execution and delivery hereof and thereof. Such representations and warranties have been or will be relied upon by the Administrative Agent and each Lender, regardless of any investigation made by the Administrative Agent or any Lender or on their behalf and notwithstanding that the Administrative Agent or any Lender may have had notice or knowledge of any Default at the time of any Credit Extension, and shall continue in full force and effect as long as any Loan or any other Obligation hereunder shall remain unpaid or unsatisfied or any Letter of Credit shall remain outstanding.

Section 10.14 Severability. If any provision of this Agreement or the other Loan Documents is held to be illegal, invalid or unenforceable, (a) the legality, validity and enforceability of the remaining provisions of this Agreement and the other Loan Documents shall not be affected or impaired thereby and (b) the parties shall endeavor in good faith negotiations to replace the illegal, invalid or unenforceable provisions with valid provisions the economic effect of which comes as close as possible to that of the illegal, invalid or unenforceable provisions. The invalidity of a provision in a particular jurisdiction shall not invalidate or render unenforceable such provision in any other jurisdiction.

Section 10.15 Tax Forms. (a) (i) Each Lender that is not a "United States person" within the meaning of Section 7701(a)(30) of the Code (a "Foreign Lender") shall deliver to the Administrative Agent, prior to receipt of any payment subject to withholding under the Code (or upon accepting an assignment of an interest herein), two duly signed completed copies of either IRS Form W-8BEN or any successor thereto (relating to such Foreign Lender and entitling it to an exemption from, or reduction of, withholding tax on all payments to be made to such Foreign Lender by the Borrower pursuant to this Agreement) or IRS Form W-8ECI or any successor thereto (relating to all payments to be made to such Foreign Lender by the Borrower pursuant to this Agreement) or such other evidence satisfactory to the Borrower and the Administrative Agent that such Foreign Lender is entitled to an exemption from, or reduction of, U.S. withholding tax, including any exemption pursuant to Section 881(c) of the Code. Thereafter and from time to time, each such Foreign Lender shall (A) promptly submit to the Administrative Agent such additional duly completed and signed copies of one of such forms (or such successor forms as shall be adopted from time to time by the relevant United States taxing authorities) as may then be available under then current United States Laws to avoid, or such evidence as is satisfactory to the Borrower and the Administrative Agent of any available exemption from or reduction of, United States withholding taxes in respect of all payments to be made to such Foreign Lender by the Borrower pursuant to this Agreement, (B) promptly notify the Administrative Agent of any change in circumstances which would modify or render invalid any claimed exemption or reduction, and (C) take such steps as shall not be materially disadvantageous to it, in the reasonable judgment of such Lender, and as may be reasonably necessary (including the re-designation of its Lending Office) to avoid any requirement of applicable Law that the Borrower make any deduction or withholding for taxes from amounts payable to such Foreign Lender.

(ii) Each Foreign Lender, to the extent it does not act or ceases to act for its own account with respect to any portion of any sums paid or payable to such Lender under any of the Loan Documents (for example, in the case of a typical participation by such Lender), shall deliver to the Administrative Agent on the date when such Foreign Lender ceases to act for its own account with respect to any portion of any such sums paid or payable, and at such other times as may be necessary in the determination of the Administrative Agent (in the reasonable exercise of its discretion), (A) two duly signed completed copies of the forms or statements required to be provided by such Lender as set forth above, to establish the portion of any such sums paid or payable with respect to which such Lender acts for its own account that is not subject to U.S. withholding tax, and (B) two duly signed completed copies of IRS Form W-8IMY (or any successor thereto), together with any information such Lender chooses to transmit with such form, and any other certificate or statement of exemption required under the Code, to establish that such Lender is not acting for its own account with respect to a portion of any such sums payable to such Lender.

(iii) The Borrower shall not be required to pay any additional amount to any Foreign Lender under Section 3.01 (A) with respect to any Taxes required to be deducted or withheld on the basis of the information, certificates or statements of exemption such Lender transmits with an IRS Form W-8IMY pursuant to this Section 10.15(a) or (B) if such Lender shall have failed to satisfy the foregoing provisions of this Section 10.15(a); provided that if such Lender shall have satisfied the requirement of this Section 10.15(a) on the date such Lender became a Lender or ceased to act for its own account with respect to any payment under any of the Loan Documents, nothing in this Section 10.15(a) shall relieve the Borrower of its obligation to pay any amounts pursuant to Section 3.01 in the event that, as a result of any change in any applicable Law or order, or any change in the interpretation, administration or application thereof, such Lender is no longer properly entitled to deliver forms, certificates or other evidence at a subsequent date establishing the fact that such Lender or other Person for the account of which such Lender receives any sums payable under any of the Loan Documents is not subject to withholding or is subject to withholding at a reduced rate; provided, further, that should such Lender become subject to Taxes because of its failure to satisfy the foregoing provisions of this Section 10.15(a) the Borrower shall take steps as such Lender shall reasonably request to assist such Lender in recovering such Taxes.

(iv) The Administrative Agent may, without reduction, withhold any Taxes required to be deducted and withheld from any payment under any of the Loan Documents with respect to which the Borrower is not required to pay additional amounts under Section 3.01 or this Section 10.15(a).

(b) Upon the request of the Administrative Agent, each Lender that is a "United States person" within the meaning of Section 7701(a)(30) of the Code shall deliver to the Administrative Agent two duly signed completed copies of IRS Form W-9. If such Lender fails to deliver such forms, then the Administrative Agent may withhold from any interest payment to such Lender an amount equivalent to the applicable back-up withholding tax imposed by the Code, without reduction.

(c) If any Governmental Authority asserts that the Administrative Agent did not properly withhold or backup withhold, as the case may be, any Tax or other amount from payments made to or for the account of any Lender, such Lender shall indemnify the Administrative Agent therefor, including all penalties and interest, any Taxes imposed by any jurisdiction on the amounts payable to the Administrative Agent under this Section, and costs and expenses (including Attorney Costs) of the Administrative Agent. The obligation of the Lenders under this Section shall survive the termination of the Aggregate Commitments, repayment of all other Obligations hereunder and the resignation of the Administrative Agent.

Section 10.16 [Intentionally omitted.]

Section 10.17 Governing Law.

(a) THIS AGREEMENT SHALL BE GOVERNED BY, AND CONSTRUED IN ACCORDANCE WITH, THE LAW OF THE STATE OF NEW YORK APPLICABLE TO AGREEMENTS MADE AND TO BE PERFORMED ENTIRELY WITHIN SUCH STATE; PROVIDED THAT THE ADMINISTRATIVE AGENT AND EACH PARTY HERETO SHALL RETAIN ALL RIGHTS ARISING UNDER FEDERAL LAW.

(b) ANY LEGAL ACTION OR PROCEEDING WITH RESPECT TO THIS AGREEMENT OR ANY OTHER LOAN DOCUMENT MAY BE BROUGHT IN THE COURTS OF THE STATE OF NEW YORK SITTING IN NEW YORK COUNTY OR OF THE UNITED STATES FOR THE SOUTHERN DISTRICT OF SUCH STATE, AND BY EXECUTION AND DELIVERY OF THIS AGREEMENT, THE BORROWER, THE ADMINISTRATIVE AGENT AND EACH LENDER CONSENTS, FOR ITSELF AND IN RESPECT OF ITS PROPERTY, TO THE NON-EXCLUSIVE JURISDICTION OF THOSE COURTS. THE BORROWER, THE ADMINISTRATIVE AGENT AND EACH LENDER IRREVOCABLY WAIVES ANY OBJECTION, INCLUDING ANY OBJECTION TO THE LAYING OF VENUE OR BASED ON THE GROUNDS OF FORUM NON CONVENIENS, WHICH IT MAY NOW OR HEREAFTER HAVE TO THE BRINGING OF ANY ACTION OR PROCEEDING IN SUCH JURISDICTION IN RESPECT OF ANY LOAN DOCUMENT OR OTHER DOCUMENT RELATED THERETO. THE BORROWER HEREBY IRREVOCABLY APPOINTS CT CORPORATION SYSTEM IN NEW YORK, NEW YORK AS ITS AUTHORIZED AGENT TO ACCEPT AND ACKNOWLEDGE SERVICE OF ANY AND ALL PROCESS WHICH MAY BE SERVED IN ANY SUIT, ACTION OR PROCEEDING OF THE NATURE REFERRED TO IN THIS SECTION 10.17 AND CONSENTS TO PROCESS BEING SERVED IN ANY SUCH SUIT, ACTION OR PROCEEDING UPON CT CORPORATION SYSTEM IN NEW YORK, NEW YORK IN ANY MANNER OR BY THE MAILING OF A COPY THEREOF BY REGISTERED OR CERTIFIED MAIL, POSTAGE PREPAID, RETURN RECEIPT REQUESTED, TO THE BORROWER'S ADDRESS REFERRED TO IN SECTION 10.02. THE BORROWER AGREES THAT SUCH SERVICE (i) SHALL BE DEEMED IN EVERY RESPECT EFFECTIVE SERVICE OF PROCESS UPON IT IN ANY SUCH SUIT, ACTION OR PROCEEDING AND (ii) SHALL, TO THE FULLEST EXTENT PERMITTED BY LAW, BE TAKEN AND HELD TO BE VALID PERSONAL SERVICE UPON AND PERSONAL DELIVERY TO IT. NOTHING IN THIS SECTION 10.17 SHALL AFFECT THE RIGHT OF ANY OTHER PARTY TO THIS AGREEMENT TO SERVE PROCESS IN ANY MANNER

PERMITTED BY LAW OR LIMIT THE RIGHT OF ANY OTHER PARTY TO THIS AGREEMENT TO BRING PROCEEDINGS AGAINST THE BORROWER IN THE COURTS OF ANY JURISDICTION OR JURISDICTIONS.

Section 10.18 Waiver of Right to Trial by Jury. THE BORROWER, THE ADMINISTRATIVE AGENT AND THE LENDERS EACH HEREBY EXPRESSLY WAIVES THEIR RESPECTIVE RIGHTS TO TRIAL BY JURY OF ANY CLAIM, DEMAND, ACTION OR CAUSE OF ACTION BASED UPON OR ARISING OUT OF OR RELATED TO THIS AGREEMENT OR ANY OTHER LOAN DOCUMENT OR IN ANY WAY CONNECTED WITH OR RELATED OR INCIDENTAL TO THE DEALINGS OF THE PARTIES HERETO OR ANY OF THEM WITH RESPECT TO ANY LOAN DOCUMENT OR THE TRANSACTIONS RELATED THERETO, IN EACH CASE WHETHER NOW EXISTING OR HEREAFTER ARISING, IN ANY ACTION, PROCEEDING OR OTHER LITIGATION OF ANY TYPE BROUGHT BY ANY OF THE PARTIES AGAINST ANY OTHER PARTY OR ANY AGENT-RELATED PERSON, PARTICIPANT OR ASSIGNEE WHETHER FOUNDED IN CONTRACT OR TORT OR OTHERWISE. THE BORROWER, THE ADMINISTRATIVE AGENT AND THE LENDERS EACH HEREBY AGREE AND CONSENT THAT ANY SUCH CLAIM, DEMAND, ACTION OR CAUSE OF ACTION SHALL BE DECIDED BY COURT TRIAL WITHOUT A JURY, AND THAT ANY PARTY TO THIS AGREEMENT MAY FILE AN ORIGINAL COUNTERPART OR A COPY OF THIS SECTION WITH ANY COURT AS WRITTEN EVIDENCE OF THE CONSENT OF THE SIGNATORIES HERETO TO THE WAIVER OF THEIR RIGHT TO TRIAL BY JURY.

Section 10.19 Replacement of Lenders. Under any circumstances set forth herein providing that the Borrower shall have the right to replace a Lender as a party to this Agreement, the Borrower may, upon notice to such Lender and the Administrative Agent (with a copy to the other Lenders), replace such Lender by causing such Lender to assign its Commitment (with the assignment fee to be paid by the Borrower in such instance) pursuant to Section 10.07(b) to one or more other Lenders or Eligible Assignees procured by the Borrower; provided, however, that if the Borrower elects to exercise such right with respect to any Lender pursuant to Section 3.06(b), it shall be obligated to replace all Lenders that have made similar requests for compensation pursuant to Section 3.01 or 3.04 who also request replacement pursuant to this Section 10.19 within ten (10) days after receipt of a copy of the Borrower's notice of exercise. The Borrower shall (x) pay in full all principal, interest, fees and other amounts owing to such Lender through the date of replacement (including any amounts payable pursuant to Section 3.05), (y) provide appropriate assurances and indemnities (which may include letters of credit) to the L/C Issuer as it may reasonably require with respect to any continuing obligation to fund participation interests in any L/C Obligations and (z) release such Lender from its obligations under the Loan Documents. Any Lender being replaced shall execute and deliver an Assignment and Assumption with respect to such Lender's Commitment and outstanding Loans and participations in L/C Obligations.

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be duly executed as of the date first above written.

MOLINA HEALTHCARE, INC., a California corporation, as the Borrower

By: /s/ JOHN C. MOLINA

Name: John C. Molina

Title: Executive Vice President

BANK OF AMERICA, N.A., as
Administrative Agent

By: /s/ JOSEPH L. CORAH

Name: Joseph L. Corah

Title: Principal

CIBC WORLD MARKETS CORP. as
Syndication Agent

By: /s/ TERENCE MOORE

Name: Terence Moore

Title: Executive Director

BANK OF AMERICA, N.A., as a Lender and L/C Issuer

By: /s/ Joseph L. Corah

Name: Joseph L. Corah

Title: Principal

CIBC INC., as Lender

By: /s/ Terence Moore

Name: Terence Moore

Title: Executive Director

SOCIETE GENERALE, as Lender

By: Richard Bernof

Name: Richard Bernof

Title: Director

U.S. BANK NATIONAL ASSOCIATION, as Lender

By: Christian E. Stein III

Name: Christian E. Stein III

Title: Vice President

EAST WEST BANK, as Lender

By: /s/ DOUGLAS P. KRAUSE

Name: Douglas P. Krause

Title: Executive Vice President

SCHEDULE 10.02

ADMINISTRATIVE AGENT'S OFFICE,
CERTAIN ADDRESSES FOR NOTICES

MOLINA HEALTHCARE, INC., a California corporation:
One Golden Shore Drive
Long Beach, CA 90802
Attention: John C. Molina, Executive Vice President
Telephone: (562) 435-3666, Ext. 1128
Facsimile: (562) 495-7770
Electronic Mail: johnmo@molinahealthcare.com

ADMINISTRATIVE AGENT:

Administrative Agent's Office (for payments and Requests for Credit Extensions):
Bank of America, N.A.
Street Address
Attention: Laura Schultz
Telephone: 704-388-6484
Facsimile: 704-409-0008
Electronic Mail: laura.a.schultz@bankofamerica.com
Account No.: 1366212250600
Ref: Molina Healthcare, Inc.
ABA# 053000196

Other Notices as Administrative Agent:
Bank of America, N.A.
Agency Management
1455 Market Street
Mail Code: CA5-701-05-19
San Francisco, CA 94103
Attention: Cassandra McCain
Telephone: 415-436-3400
Facsimile: 415-503-5133
Electronic Mail: cassandra.g.mccain@bankofamerica.com

With a copy to:
Bank of America, N.A.
Healthcare Portfolio Management
100 North Tryon Street
Mail Code: NC1-007-17-11
Charlotte, NC 28255
Attention: Joseph Corah
Telephone: 704-386-5976
Facsimile: 704-388-6002
Electronic Mail: joseph.l.corah@bankofamerica.com

L/C ISSUER:

Bank of America, N.A.
Trade Operations-Los Angeles #22621
333 S. Beaudry Avenue, 19th Floor
Mail Code: CA9-703-19-23
Los Angeles, CA 90017-1466
Attention: Sandra Leon
Vice President
Telephone: 213.345.5231
Facsimile: 213.345.6694
Electronic Mail: Sandra.Leon@bankofamerica.com

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 report dated January 31, 2003 (except Note 10 and Note 12, as to which the dates are   , 2003 and March 21, 2003, respectively), included in the Registration Statement (Form S-1 No. 333-102268) 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
April 11, 2003