SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

FORM 10-K

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

For the fiscal year ended December 31, 2003

Commission File Number 1-31719

MOLINA HEALTHCARE, INC.

(Exact name of Registrant as specified in its charter)

Delaware	**13-4204626**
(State or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification No.)**

One Golden Shore Drive, Long Beach, California 90802
(Address of principal executive offices)

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

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

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

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

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

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

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

The aggregate market value of Common Stock held by non-affiliates of the Registrant as of February 13, 2004 was approximately $219,823,178 (based upon the closing price for shares of the Registrant's Common Stock as reported by the New York Stock Exchange, Inc. on such date).

As of February 13, 2004, approximately 25,418,255 shares of the Registrant's Common Stock, $0.001 par value per share, were outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the Registrant's Proxy Statement for the 2004 Annual Meeting of Stockholders to be held on or about May 12, 2004, are incorporated by reference into Part III of this Form 10-K.

MOLINA HEALTHCARE, INC.

Table of Contents

Form 10-K

PART I

Item 1: *Business*

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. C. David Molina, M.D., founded our company in 1980 as a provider organization serving the Medicaid population through a network of primary care clinics in California. We recognized the growing need for more effective management and delivery of health care services to underserved Medicaid beneficiaries and became licensed as an HMO. We have grown 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. In July 2003 we completed our initial public offering of common stock. As of December 31, 2003, we had approximately 564,000 members.

Our members have distinct social and medical needs and are characterized by their cultural, ethnic and linguistic diversity. From our inception, we have designed our company to work with government agencies to serve low-income populations. Our success has resulted from our expertise in working with government agencies, our extensive experience with meeting the needs of our members, our 24 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 $793.5 million in 2003. Over the same period, our net income grew from $2.6 million to $42.5 million due to our effective medical management programs and our ability to leverage fixed and administrative costs. In California, our largest market in terms of membership, we have been successful in an environment characterized by significant competition, heavy regulation and among the lowest state Medicaid expenditure rates per beneficiary in the U.S. In Washington we have been able to earn substantial market share as a result of our strong provider network and efficient operations. In Utah, we have worked with the state government to successfully lower medical costs without harming the quality of medical care. In Michigan, we have more than doubled our membership in 2003. We believe that 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. 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 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. Typically, this percentage match is at least 50%. Federal payments for Medicaid have no set dollar ceiling and are limited only by the amount states are willing to spend. State and local governments pay the share of Medicaid costs not paid by the federal government.

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

Under traditional Medicaid programs, health care services are made available to beneficiaries in an uncoordinated manner. These individuals typically have minimal access to preventive care such as

immunizations, and access to primary care physicians is limited. As a consequence, treatment is often postponed until medical conditions become more severe, leading to higher utilization of costly emergency room services. In addition, providers are paid on a fee-for-service basis and lack incentive to monitor utilization and control costs.

In an effort to provide improved, more uniform and more cost-effective care, most states have implemented Medicaid managed care programs. Such programs seek to improve access to coordinated health care services, including preventive care, and to control health care costs. Under Medicaid managed care programs, a health plan 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 striving to improve access to care while more effectively controlling costs.

Over the past decade, the federal government has expanded the ability of state Medicaid agencies to explore, and, in many cases, mandate the use of managed care for Medicaid beneficiaries. If Medicaid managed care is not mandatory, individuals entitled to Medicaid may choose either the fee-for-service Medicaid program or a managed care plan, if available. All states in which we operate have 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 within a managed care model. We believe we are well positioned to capitalize on the growth opportunities in our markets. Our approach to managed care is based on the following key attributes:

Experience. For 24 years we have focused on serving Medicaid beneficiaries as both a health plan and as a provider. In that time we have developed and forged strong relationships with the constituents whom we serve — members, providers and government agencies. Our ability to deliver quality care and to establish and maintain provider networks, as well as our administrative efficiency, have allowed us to compete successfully for government contracts. We have a very strong record of obtaining and renewing contracts and have developed significant expertise as a government contractor.

Administrative Efficiency. We have centralized and standardized various functions and practices across all of our health plans to increase administrative efficiency. These include centralized claims processing and information services operating 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 into 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 acquisitions in Michigan and Washington have demonstrated our ability to acquire and successfully integrate existing health plan operations into our own business model. For example, since our acquisition in Washington on December 31, 1999, membership has increased from approximately 60,000 members to approximately 183,000 members as of December 31, 2003 while profitability has 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 that state with 45,000 members as of December 31, 2003. Our Michigan HMO added 49,000 members in 2003. A substantial portion of that growth was from the successful integration of members from competing multi-product health plans that exited the Medicaid 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 expertise, proximity, cultural sensitivity and experience, to provide services to the membership we serve.

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

Cultural and Linguistic Expertise. National census data shows that the population is becoming increasingly diverse. We have a 24-year history of developing targeted health care programs for our culturally diverse membership and believe we are well-positioned to successfully serve these growing populations. We contract with a diverse network of community-oriented providers who have the capabilities to address the linguistic and cultural needs of our members. We have established cultural advisory committees in all of our major markets. Our full-time cultural anthropologist advises these cultural advisory committees. We educate employees and providers about the differing needs among our members. We develop member education material in a variety of media and languages and ensure that the literacy level is appropriate for our target audience. In addition, our website is accessible in six languages.

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

Our Strategy

Our objective is to be the leading managed care organization serving Medicaid and State Children's Health Insurance Program members. To achieve this objective, we intend to:

Focus on serving low-income families and individuals. We believe that the Medicaid population, characterized by low income and significant ethnic diversity, requires unique services to meet its health care needs. Our 24 years of experience in serving this population has provided us significant expertise in meeting the unique needs of our members. We will continue to focus on serving the beneficiaries of Medicaid and other government-sponsored programs, as our experience, infrastructure and health care programs position us to optimally serve this population.

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

- *Expand within existing markets.* We expect to grow in existing markets by expanding our service areas and provider networks, increasing awareness of the Molina brand name, maintaining positive provider relationships and integrating members from other health plans.

- *Enter new markets*. We intend to enter new markets by acquiring existing businesses or building our own operations. We will focus our expansion on markets with strong provider dynamics, a fragmented competitive landscape, significant size and mandated Medicaid managed care enrollment.

Manage medical costs. We will continue to use our information systems, positive provider relationships and first-hand provider experience to further develop and utilize effective medical management and other programs that address the distinct needs of our members. While improving the efficacy of treatment, these programs facilitate the identification of our members with special or 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, allowing 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 provided in the table below:

Summary of Health Plans as of December 31, 2003

State	Total Members	Number of Contracts	Expiration Date
California	254,000	5	Varies between June 30, 2004 and March 31, 2005
Washington	183,000	2	December 31, 2004 and December 31, 2005
Michigan	82,000	1	September 30, 2004
Utah	45,000	2	June 30, 2004 and June 30, 2006

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 and Michigan. Since July 1, 2002 our Utah health plan has been reimbursed by the state for all medical costs incurred by Medicaid members plus a 9% administrative fee. Our contracts in Washington and Michigan have higher monthly payments than in California, but require us to cover more services. In California, the state retains responsibility for certain high cost services, such as specified organ transplants and pediatric oncology cases. In general, either party may terminate our state contracts with or without cause upon 30 days to nine months prior written notice. In addition, most of these contracts contain renewal options that are exercisable by the state.

California. Molina Healthcare of California 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. Molina Healthcare of Washington, Inc. is now the largest Medicaid managed health plan in the state, with 183,000 members at December 31, 2003. We serve members in 30 of the state's 39 counties.

Michigan. Membership of Molina Healthcare of Michigan grew to 82,000 members at December 31, 2003 from 33,000 members at December 31, 2002. Effective August 1, 2003 approximately 9,400 members were

transferred to our Michigan HMO under the terms of an agreement with another health plan. Effective October 1, 2003 approximately 32,000 members were transferred to our Michigan HMO under the terms of an agreement with yet another health plan. Our Michigan HMO serves the metropolitan Detroit area, as well as over 30 other counties throughout Michigan.

Utah. Molina Healthcare of Utah, Inc. is the largest Medicaid managed care health plan in Utah. We serve Salt Lake County as well as fourteen other counties that collectively contain over 80% of the population in the state. Effective July 1, 2002, our contract was amended to provide us a stop loss guarantee for the first 40,000 Medicaid members. Of the Utah HMO's 45,000 members at December 31, 2003, approximately 38,000 are Medicaid members, with State Children's Health Insurance Program members comprising the remainder. 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 to Medicaid members. 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. Our Utah health plan is compensated for coverage offered to State Children's Health Insurance Program members on a per member per month basis.

Provider Networks

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

The following table shows the total approximate number of primary care physicians, specialists and hospitals participating in our network as of December 31, 2003:

	California	Washington	Michigan	Utah	Total
Primary care physicians	2,099	1,917	657	956	5,629
Specialists	6,879	4,788	1,375	1,273	14,315
Hospitals	112	80	37	19	248

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 2003, the clinics had over 153,000 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 members. The clinics assist us in developing and implementing community education, disease management and other programs. The clinics also give us direct clinic management experience that enables us to better understand the needs of our contracted providers.

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

Medical Management

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

Disease Management. We develop specialized disease management programs that address the particular health care needs of our members. "*motherhood matters*[sm]" is a comprehensive program designed to improve pregnancy outcomes and enhance member satisfaction. "*Breathe with Ease*[sm]" is a multidisciplinary disease management program that provides intensive health education resources and case management services to assist physicians caring for asthmatic members between the ages of three and fifteen. We anticipate that both of these programs will be fully implemented in all four states in which we operate.

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

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

Plan Administration and Operations

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

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

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

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

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

Competition

The Medicaid managed care industry is highly fragmented. We compete with a large number of national, regional and local Medicaid service providers. Below is a general description of our principal competitors for state contracts, members and providers:

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

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

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

Regulation

Our health plans are regulated by both state and federal government agencies. Regulation of managed care products and health care services is an evolving area of law that varies from jurisdiction to jurisdiction. Regulatory agencies generally have discretion to issue regulations and interpret and enforce laws and rules. Changes in applicable laws and rules occur frequently.

In order to operate a health plan in a given state, we must apply for and obtain a certificate of authority or license from that state. Our health plans are licensed to operate as HMOs in California, Washington, Michigan and Utah. In those states we are regulated by the agency with responsibility for the oversight of HMOs. In most

cases that agency is the state department of insurance. In Californian that agency is the Department of Managed Health Care. Licensing requirements are the same for us as they are for health plans serving commercial or Medicare members. We must demonstrate that our provider network is adequate, that our quality and utilization management processes comply with state requirements, and that we have adequate procedures in place for responding to member and provider complaints and grievances. We must also demonstrate that we can meet requirements for the timely processing of provider claims, and that we can collect and analyze the information needed to manage our quality improvement activities. In addition, we must prove that we have the financial resources necessary to pay our anticipated medical care expenses and the infrastructure needed to account for our costs.

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

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

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

- establishes its own eligibility standards,
- determines the type, amount, duration and scope of services,
- sets the rate of payment for services, and
- administers its own program.

We obtain our Medicaid contracts in different ways. Some states, such as Washington, award contracts to any applicant demonstrating that it meets the state's requirements. Others, such as California, engage in a competitive bidding process. In 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 be able to meet the needs of the disabled and others with special needs,

- Our providers and member service representatives must be able to communicate with members who do not speak English or who are deaf, and
- Our member handbook, newsletters and other communications must be written at the prescribed reading level, and must be available in languages other than English.

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

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

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

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

The Federal Centers for Medicare and Medicaid Services are still working to adopt final regulations to fully implement HIPPA. We expect to achieve compliance with HIPAA by the applicable deadlines. However, given the complexity of HIPPA, the recent adoption of some final regulations, the need to adopt additional final regulations, the possibility that the regulations may change and may be subject to changing, and perhaps conflicting, interpretation, our ability to comply with all HIPAA requirements is uncertain and the cost of compliance not yet determined.

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

Employees: As of December 31, 2003, we had approximately 893 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. None of our employees are represented by a union.

Item 2: ***Properties***

We lease a total of 34 facilities, including 21 medical clinics in California. We own a 32,000 square-foot office building in Long Beach, California, which serves as our corporate headquarters.

Item 3: ***Legal Proceedings***

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.

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

At our 2003 Annual Meeting of Stockholders held on December 4, 2003, our stockholders elected as Class I Directors George S. Goldstein, Ph.D. and Ronald Lossett, CPA, D.B.A. Our stockholders also ratified the selection of Ernst & Young LLP as our independent accountants for the fiscal year ending December 31, 2003.

Mr. Goldstein received 23,257,919 votes; 579,893 votes were withheld. Mr. Lossett received 21,608,746 votes; 2,229,066 votes were withheld. The ratification of Ernst & Young LLP as our independent accountants received 21,777,856 votes for, 2,059,956 votes against and no abstentions.

The terms of office of the following other directors continued after the meeting: J. Mario Molina, M.D., John C. Molina, J.D., Ronna Romney, Charles Z. Fedak, CPA, M.B.A. and Sally K. Richardson.

PART II

Item 5: ***Market for Registrant's Common Equity and Related Stockholder Matters***

As of December 31, 2002, there was no established public trading market for any class of our common equity. Subsequently, our common stock became listed on July 2, 2003 on The New York Stock Exchange, Inc. under the symbol "MOH." The high and low sales prices of our common stock for specified periods are set forth below:

Date Range	High Sales Price	Low Sales Price
July 2, 2003 to September 30, 2003	$27.75	$20.15
October 1, 2003 to December 31, 2003	$29.00	$21.75

As of February 13, 2004, there were approximately 1,318 holders of our common stock.

We have in the past declared and paid cash dividends on our common stock. There were no dividends declared in 2003, 2002, 2001 or 1999. 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.

Securities Authorized for Issuance Under Equity Compensation Plans (as of December 31, 2003)

Plan Category	Number of shares to be issued upon exercise of outstanding options, warrants and rights (a)	Weighted average exercise price of outstanding options, warrants and rights (b)	Number of shares remaining available for future issuance under equity compensation plans (excluding securities reflected in column (a) (c)
Equity compensation plans approved by security holders	797,200(1)	$ 4.77	2,546,640(2)

(1) Options to purchase shares of our common stock issued under the 2000 Omnibus Stock and Incentive Plan. All such options vested upon the completion of our initial public offering of common stock in July 2003. Further grants under the 2000 Omnibus Stock and Incentive Plan have been frozen.

(2) Includes only shares issuable under the 2002 Equity Incentive Plan. The number of shares available for issuance under equity compensation plans will automatically increase by the lesser of 400,000 shares or 2% of total outstanding capital stock on a fully diluted basis on January 1, 2004 and on each January 1 thereafter, unless the Board determines that such automatic increase is not needed.

Use of Proceeds from Initial Public Offering

On July 8, 2003 we completed our initial public offering of 7,590,000 shares of common stock, par value $0.001 per share. Managing underwriters for the offering were Banc of America Securities LLC and CIBC World Markets Corp. as joint book-running managers and SG Cowen Securities Corporation as co-manager. The shares of common stock sold in the offering were registered under the Securities Act of 1933, as amended, on a Registration Statement on Form S-1, Registration Number 333-102268, which was declared effective by the Securities and Exchange Commission on July 1, 2003. The offering commenced on July 2, 2003. All of the

7,590,000 shares sold by the Company were issued at a price of $17.50 per share. We received net proceeds from the offering of approximately $119.6 million, after deducting approximately $3.9 million in fees and expenses and approximately $9.3 million in underwriters' discount. We used a portion of the proceeds from the offering to repay the then outstanding balance of $8.5 million on our credit facility. Additionally, we used a portion of the proceeds to complete a previously contemplated repurchase of an aggregate of 1,120,571 shares of our common stock from two stockholders for $17.50 per share, or an aggregate purchase price of $19.6 million. In such transaction, we purchased 912,806 shares owned by the MRM GRAT 301/2 and 207,765 shares owned by the Mary R. Molina Living Trust. In September 2003, we used $3.75 million of the proceeds to complete the previously contemplated transfer of certain members to our Michigan HMO. We intend to use the balance of approximately $87.75 million of such net proceeds for general corporate purposes, including acquisitions.

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

SELECTED CONSOLIDATED FINANCIAL DATA

We derived the following selected consolidated financial data for the five years ended December 31, 2003 from our audited consolidated financial statements. You should read the data in conjunction with our consolidated financial statements, related notes and other financial information included herein. All dollars are in thousands, except per share data.

	Year Ended December 31,				
	2003(1)	**2002(1)**	**2001(1)**	**2000(1)**	**1999**
Statements of Income Data:					
Revenue:					
Premium revenue	$ 789,536	$ 639,295	$ 499,471	$ 324,300	$ 181,929
Other operating revenue	2,247	2,884	1,402	1,971	2,358
Investment income	1,761	1,982	2,982	3,161	1,473
Total operating revenue	793,544	644,161	503,855	329,432	185,760
Expenses:					
Medical care costs	657,921	530,018	408,410	264,408	148,138
Marketing, general and administrative expenses (including a charge for stock option settlements of $7,796 in 2002)	61,543	61,227	42,822	38,701	18,511
Depreciation and amortization	6,333	4,112	2,407	2,085	1,625
Total expenses	725,797	595,357	453,639	305,194	168,274
Operating income	67,747	48,804	50,216	24,238	17,486
Total other expense, net	(1,334)	(405)	(561)	(197)	(1,190)
Income before income taxes	66,413	48,399	49,655	24,041	16,296
Provision for income taxes	23,896	17,891	19,453	9,156	6,576
Income before minority interest	42,517	30,508	30,202	14,885	9,720
Minority interest	—	—	(73)	79	(267)
Net income	$ 42,517	$ 30,508	$ 30,129	$ 14,964	$ 9,453
Net income per share:					
Basic	$ 1.91	$ 1.53	$ 1.51	$ 0.75	$ 0.47
Diluted	$ 1.88	$ 1.48	$ 1.46	$ 0.73	$ 0.47
Cash dividends declared per Share	—	—	—	$ 0.05	—
Weighted average number of common shares outstanding (2)	22,224,000	20,000,000	20,000,000	20,000,000	20,000,000
Weighted average number of common shares and potential dilutive common shares outstanding (2)	22,629,000	20,609,000	20,572,000	20,376,000	20,173,000
Operating Statistics:					
Medical care ratio (3)	83.1%	82.5%	81.5%	81.0%	80.4%
Marketing, general and administrative expense ratio (4)	7.8%	9.5%	8.5%	11.7%	10.0%
Members (5)	564,000	489,000	405,000	298,000	199,000

	As of December 31,				
	2003	2002(1)	2001(1)	2000(1)	1999
Balance Sheet Data:					
Cash and cash equivalents	$141,850	$139,300	$102,750	$ 45,785	$ 26,120
Total assets	344,585	204,966	149,620	102,012	101,636
Long-term debt (including current maturities)	—	3,350	3,401	3,448	17,296
Total liabilities	123,263	109,699	84,861	67,405	80,991
Stockholders' equity	221,322	95,267	64,759	34,607	20,645

(1) The balance sheet and operating results of the Washington health plan have been included in the consolidated balance sheet as of December 31, 1999, the date of acquisition, and in each of the consolidated statements of income for periods thereafter.

(2) The weighted average number of common shares and potential dilutive common shares outstanding for 1999 has been adjusted to reflect a share exchange in 1999 in which each share of Molina Healthcare of California (formerly Molina Medical Centers) was exchanged for 5,000 shares of Molina Healthcare, Inc. (formerly American Family Care, Inc.), and Molina Healthcare, Inc. became the parent company.

(3) Medical care ratio represents medical care costs as a percentage of premium and other operating revenue. Other operating revenue includes revenues related to our California clinics and reimbursements under various risks and savings sharing programs. 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.

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

(5) Number of members at end of period.

Item 7. ***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 report. 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 "Forward-Looking Statements" and "Business" and elsewhere in this report.

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 and our other reports filed with the Securities and Exchange Commission 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, vision or other benefits. In some cases, changes in funding could be made retroactive. All of the states in which we operate are presently considering legislation that would reduce reimbursement or payment levels by the state governments or reduce the number of persons eligible for Medicaid. 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 March 2005, unless they are renewed. In Washington, our Healthy Options contract will expire in December 2005, if not renewed. In Utah,

our contract expires in June 2004. In Michigan our contract expires in September 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.

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 2003, we had total revenue of $793.5 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 make certain acquisitions and declare dividends.

We secured a $75.0 million credit facility which we plan to use for general corporate purposes and acquisitions. Our credit facility documents contain various restrictions and covenants, including prescribed debt coverage ratios, net worth requirements and acquisition limitations, that restrict our financial and operating flexibility, including our ability to make certain acquisitions above specified values and declare dividends without lender approval. Our growth strategy my be negatively impacted by our inability to act with complete flexibility.

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

Our operations are highly dependent on the efforts of our President and Chief Executive Officer and our Executive Vice Presidents, 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 $1 million per occurrence and an annual aggregate limit of $3 million, and such other lines of coverage as we believe are reasonable in light of our experience to date. However, this insurance may not be sufficient or available at a reasonable cost to protect us from damage awards or other liabilities. Even if any claims brought against us were unsuccessful or without merit, we would have to defend ourselves against such claims. The defense of any such actions may be time-consuming and costly, and may distract our management's attention. As a result, we may incur significant expenses and may be unable to effectively operate our business.

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

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

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

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

We principally operate through our health plan subsidiaries. These subsidiaries are subject to laws and regulations that limit the amount of dividends and distributions that they can pay to us without prior approval of, or notification to, state regulators. In California, our health plan may dividend, without notice to or approval of the California Department of Managed Health Care, amounts by which its tangible net equity exceeds 130% of the tangible net equity requirement. In Michigan, Utah and Washington, our health plans must give thirty days advance notice and the opportunity to disapprove "extraordinary" dividends to the respective state departments of insurance for amounts over the lesser of (a) ten percent of surplus or net worth at the prior year end or (b) the net income for the prior year. The discretion of the state regulators, if any, in approving or disapproving a dividend is not clearly defined. Health plans that declare non-extraordinary dividends must usually provide notice to the regulators ten or fifteen days in advance of the intended distribution date of the non-extraordinary dividend. The aggregate amounts our health plan subsidiaries could have paid us at December 31, 2003, 2002 and 2001 without approval of the regulatory authorities were approximately $29.0 million, $28.9 million and $22.1 million, respectively, assuming no dividends had been paid during the respective calendar years. If the regulators were to deny or significantly restrict our subsidiaries' requests to pay dividends to us, the funds available to our company as a whole would be limited, which could harm our ability to implement our business strategy. For example, we could be hindered in our ability to make debt service payments on amounts drawn from our credit facility.

Risks Associated With Our Common Stock

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 dilution with the future exercise of stock options.

As of December 31, 2003, we had outstanding options to purchase 797,200 shares of our common stock, all of which were vested. 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.

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

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

Our executive officers and directors, in the aggregate, beneficially own approximately 29.7% of our capital stock. Members of the Molina family (some of whom are also officers or directors), in the aggregate, beneficially own approximately 70.0% of our capital stock, either directly or in trusts of which members of the Molina family are beneficiaries. In some cases, members of the Molina family are trustees of the trusts. As a result, Molina family members, acting themselves or together with our officers and directors, will have the ability to 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.

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.

FORWARD-LOOKING STATEMENTS

This report 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 report entitled "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.

Overview

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

We generate revenues primarily from premiums we receive from the states in which we operate. In 2003, we received approximately 84% 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 5% of our premium revenue from the Medicaid programs in Washington and Michigan 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. Approximately 11% of our premium revenue in 2003 was realized under a cost plus reimbursement agreement that our Utah subsidiary has with that state. Premium rates are periodically adjusted by the state 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.

	As of December 31,		
Market	2003	2002	2001
California	254,000	253,000	229,000
Michigan	82,000	33,000	26,000
Utah	45,000	42,000	16,000
Washington	183,000	161,000	134,000
Total	564,000	489,000	405,000

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, 2003, approximately 75% 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 these providers. We pay hospitals in a variety of ways, including fee-for-service, per diems, diagnostic related groups and case rates.

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

service payments are expensed in the period services are provided to our members. Medical care costs include actual historical claims experience and estimates of medical expenses incurred but not reported, or IBNR. Monthly, we estimate our IBNR based on a number of factors, including prior claims experience, inpatient hospital utilization data and prior authorization of medical services. As part of this review, we also consider estimates of amounts to cover uncertainties related to fluctuations in provider billing patterns, claims payment patterns, membership and medical cost trends. These estimates are adjusted monthly as more information becomes available. We 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 MG&A services are provided locally, while others are delivered to our health plans from a centralized location. The major centralized functions are claims processing, information systems, finance and accounting 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 and (beginning in the second quarter of 2003) Michigan health plans, as those states assess taxes based on premium revenue.

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,		
	2003	2002	2001
Premium revenue	99.5%	99.2%	99.1%
Other operating revenue	0.3%	0.5%	0.3%
Investment income	0.2%	0.3%	0.6%
Total operating revenue	100.0%	100.0%	100.0%
Medical care ratio	83.1%	82.5%	81.5%
Marketing, general and administrative expenses	7.8%	9.5%	8.5%
Operating income	8.5%	7.6%	10.0%
Net income	5.4%	4.7%	6.0%

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

Premium Revenue

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

Other Operating Revenue

Other operating revenue decreased to $2.2 million for the year ended December 31, 2003 from $2.9 million for the year ended December 31, 2002. The decrease was the result of reduced savings sharing revenue at our California and Michigan HMOs.

Investment Income

Investment income for the year ended December 31, 2003 decreased to $1.8 million from $2.0 million for the year ended December 31, 2002 due to lower investment yields, which were partially offset by greater invested balances.

Medical Care Costs

Medical care costs for the year ended December 31, 2003 were $657.9 million, representing 83.1% of premium and other operating revenue for all of 2003, as compared with $530.0 million, representing 82.5% of premium and other operating revenue, for 2002. The increase in the medical care ratio was due to increases in specialty, hospital and pharmacy expense, partially offset by reduced capitation costs. Additionally, medical margins in 2003 were reduced by changes in the state of Washington's method of compensating us for certain healthcare costs reimbursed by the Supplemental Security Income program.

Marketing, General and Administrative Expenses

MG&A expenses for the year ended December 31, 2003 were $61.5 million as compared with $53.4 million (after deducting $7.8 million in stock option settlement expenses) for the year ended December 31, 2002. The increase was primarily due to an increase in premium tax expense of $4.2 million in 2003. MG&A expenses as a percentage of operating revenue were 7.8% for the year ended December 31, 2003 as compared with 8.3% (adjusted for the stock option settlement expense) for the year ended December 31, 2002.

Depreciation and Amortization

Depreciation and amortization expense for the year ended December 31, 2003 increased to $6.3 million from $4.1 million for the year ended December 31, 2002. The increase was primarily due to increased capital spending for computer equipment and leasehold improvements.

Interest Expense

Interest expense increased to $1.5 million for the year ended December 31, 2003 from $.4 million for the year ended December 31, 2002. Interest expense increased due to the amortization of loan fee expense associated with our credit facility, as well as the payment of interest on amounts borrowed under that facility. Interest expense was reduced by our repayment of a mortgage note in the second quarter of 2003.

Provision for Income Taxes

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

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

The prior year credit recognized in 2003, net of recovery fees, of $845 ($.04 per diluted share) was accounted for as a change in estimate. We are continuing to validate prior year credits and expect to recognize additional credits in 2004 as claims are filed with the state of California.

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 premium rate increases that 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 were 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. Of this increase, $9.5 million was due to increases in 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.

Acquisitions

Effective August 1, 2003 approximately 9,400 members were transferred to our Michigan HMO under the terms of an agreement with another health plan. Effective October 1, 2003 approximately 32,000 members were transferred to our Michigan HMO under the terms of an agreement with yet another health plan. Total costs associated with these two transactions were $8.9 million. In both instances the entire cost of the transaction was recorded as an identifiable intangible asset and is being amortized over 60 months.

Liquidity and Capital Resources

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

Our investment policies are designed to provide liquidity, preserve capital and maximize total return on invested assets. As of December 31, 2003, we invested a substantial portion of our cash in a portfolio of highly liquid money market securities. As of December 31, 2003, our investments consisted solely of investment grade debt securities (all of which are classified as current assets) with a maximum maturity of five years and an average duration of two years. Three professional portfolio managers operating under documented investment guidelines manage our investments. The states in which we operate prescribe the types of instruments in which our subsidiaries may invest their funds. Our restricted investments are invested principally in certificates of deposit and treasury securities with maturities of up to 12 months.

The average annualized portfolio yield for the years ended December 31, 2003, 2002 and 2001 was approximately 1.1%, 1.7% and 4.5%, respectively.

In July 2003 we completed an initial public offering of our common stock. We sold 7,590,000 shares, generating net proceeds of approximately $119.6 million after deducting approximately $3.9 million in fees, costs and expenses and $9.3 million in underwriters' discount.

Net cash provided by operating activities was $45.6 million in 2003, $45.7 million in 2002 and $61.4 million in 2001. Because we generally receive premium revenue in advance of payment for the related medical care costs (with the exception of our Utah health plan), 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 $182.2 million at December 31, 2003 and $74.6 million at December 31, 2002. At December 31, 2003 and 2002, cash, cash equivalents and investments were $240.7 million and $139.3 million, respectively. Increased working capital and cash, cash equivalent, and investment balances at December 31, 2003 were principally the result of our initial public offering of common stock and cash provided by operating activities.

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, 2003, 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 2004. We also believe that our cash resources and internally generated funds will be sufficient to support our operations, regulatory requirements and capital expenditures at least through 2004.

Credit Facility

We entered into a credit agreement dated as of March 19, 2003, under which a syndicate of lenders provided a $75.0 million senior secured revolving credit facility. We plan to use this credit facility for general corporate purposes and acquisitions. During the first six months of 2003 we borrowed a total of $8.5 million under this credit facility, and repaid the entire amount in July of 2003 with proceeds from our initial public offering of common stock.

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 of the credit facility and CIBC World Markets Corp. is the syndication agent. Bank of America, NA, CIBC Inc., an affiliate of CIBC World Markets Corp., Societe Generale, U.S. Bank National Association and East West Bank, are lenders under the credit facility. The interest rate per annum under the credit facility was initially (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. Because our initial public offering of common stock raised net proceeds in excess of $50 million, the interest rate margin has been 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 includes a sublimit for the issuance of standby and commercial letters of credit to be issued by Bank of America, NA All amounts that may be borrowed under the credit facility are due and payable in full by March 20, 2006. The credit facility is secured by substantially all of our parent company's real and personal property and the real and personal property of our non-HMO subsidiary and, subject to certain limitations, all shares of our Washington HMO subsidiary, our Michigan HMO subsidiary and both of our Utah subsidiaries. The credit facility requires us to perform within covenants and requires approval of certain acquisitions above certain prescribed thresholds. The credit facility contains customary terms and conditions, and we have incurred and will incur customary fees in connection with the credit facility.

Redemptions

In January and February 2003, prior to our initial public offering of common stock, we redeemed an aggregate of 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). The total cash payment of $20.39 million was made from available cash reserves.

In July, 2003 we completed a previously contemplated repurchase of an aggregate of 1,120,571 shares of our common stock from two stockholders for $17.50 per share or an aggregate purchase price of $19.61 million. Of such shares, we purchased 912,806 shares owned by the MRM GRAT 301/2 and 207,765 shares owned by the Mary R. Molina Living Trust. These shares were subsequently retired.

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, 2003, our HMOs had aggregate statutory capital and surplus of approximately $88.7 million, compared with the required minimum aggregate statutory capital and surplus of approximately $41.6 million. All of our HMOs were in compliance with the minimum capital requirements.

Critical Accounting Policies

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

Our medical care costs include actual historical claims experience and estimates for medical care costs incurred but not reported to us (IBNR). We, together with our independent actuaries, estimate medical claims liabilities using actuarial methods based upon historical data adjusted for payment patterns, cost trends, product mix, seasonality, utilization of health care services and other relevant factors. The estimation methods and the resulting reserves are frequently reviewed and updated, and adjustments, if necessary, are reflected in the period known. We also record reserves for estimated referral claims related to medical groups under contract with us that are financially troubled or insolvent and that may not be able to honor their obligations for the 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 for determining the required estimates. While we believe our estimates are adequate, it is possible that future events could require us to make significant adjustments or revisions to these estimates. In assessing the adequacy of accruals for medical claims liabilities, we consider our historical experience, the terms of existing contracts, our knowledge of trends in the industry, information provided by our customers and information available from other sources as appropriate.

Commitments and Contingencies

We lease office space and equipment under various operating leases. As of December 31, 2003, our lease obligations for the next five years and thereafter are as follows: $5.5 million in 2004, $5.0 million in 2005, $4.8 million in 2006, $4.2 million in 2007, $3.4 million in 2008 and an aggregate of $12.1 million thereafter.

Our headquarters building in Long Beach, California was subject to a mortgage as of December 31, 2002 of $3.35 million, which was repaid in April 2003.

We are not an obligor to or guarantor of any indebtedness of any other party. We are not a party to off-balance sheet financing arrangements except for operating leases which are disclosed in the "Commitments and Contingencies" section of our consolidated financial statements appearing elsewhere in this report and the notes thereto. We have made certain advances and loans to related parties, which are discussed in the consolidated financial statements appearing elsewhere in this report and the notes thereto.

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

Quantitative and Qualitative Disclosures About Market Risk

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

We invest a substantial portion of our cash in the CADRE Affinity Fund and CADRE Reserve Fund (CADRE Funds), a portfolio of highly liquid money market securities. The CADRE Funds are a series of funds managed by the CADRE Institutional Investors Trust (Trust), a Delaware business trust registered as an open-end management investment fund. Our investments are managed by three professional portfolio managers operating under documented investment guidelines. Restricted investments are invested principally in certificates of deposit and treasury securities. Concentration of credit risk with respect to accounts receivable is limited due to payors consisting principally of the governments of each state in which our HMO subsidiaries operate.

As of December 31, 2003 we had cash and cash equivalents of $141.9 million, investments of $98.8 million and restricted investments of $2.0 million. The cash equivalents consist of highly liquid securities with original maturities of up to three months that are readily convertible into known amounts of cash. Our investments (all of which are classified as current assets) consist solely of investment grade debt securities with a maximum maturity of five years and an average duration of two years. The restricted investments consist of interest-bearing deposits required by the respective states in which we operate. These investments are subject to interest rate risk and will decrease in value if market rates increase. All non-restricted investments are maintained at fair market value on the balance sheet. We have the ability to hold these investments until maturity, and as a result, we would not expect the value of these investments to decline significantly as a result of a sudden change in market interest rates. Declines in interest rates over time will reduce our investment income.

Inflation

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.

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

INDEX TO FINANCIAL STATEMENTS

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, 2003 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, 2003. 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, 2003 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, 2003, in conformity with accounting principles generally accepted in the United States.

/s/ ERNST & YOUNG LLP

Los Angeles, California
January 30, 2004

MOLINA HEALTHCARE, INC.

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

	December 31	
	2003	2002
ASSETS		
Current assets:		
Cash and cash equivalents	$141,850	$ 139,300
Investments	98,822	—
Receivables	53,689	29,591
Income taxes receivable	—	904
Deferred income taxes	2,442	2,083
Prepaid and other current assets	5,254	5,682
Total current assets	302,057	177,560
Property and equipment, net	18,380	13,660
Goodwill and intangible assets, net	12,284	6,051
Restricted investments	2,000	2,000
Deferred income taxes	1,996	2,287
Advances to related parties and other assets	7,868	3,408
Total assets	$344,585	$ 204,966
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Medical claims and benefits payable	$105,540	$ 90,811
Accounts payable and accrued liabilities	11,419	12,074
Income taxes payable	2,882	—
Current maturities of long-term debt	—	55
Total current liabilities	119,841	102,940
Long-term debt, less current maturities	—	3,295
Other long-term liabilities	3,422	3,464
Total liabilities	123,263	109,699
Commitments and contingencies		
Stockholders' equity:		
Common stock, $0.001 par value; 80,000,000 shares authorized; issued and outstanding: 25,373,785 shares at December 31, 2003 and 20,000,000 shares at December 31, 2002	25	5
Preferred stock, $0.001 par value; 20,000,000 shares authorized, no shares issued and outstanding	—	—
Paid-in capital	103,854	—
Accumulated other comprehensive income	54	—
Retained earnings	137,779	95,262
Treasury stock (1,201,174 shares, at cost)	(20,390)	—
Total stockholders' equity	221,322	95,267
Total liabilities and stockholders' equity	$344,585	$ 204,966

See accompanying notes.

MOLINA HEALTHCARE, INC.

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

	Year ended December 31		
	2003	**2002**	**2001**
Revenue:			
Premium revenue	$ 789,536	$ 639,295	$ 499,471
Other operating revenue	2,247	2,884	1,402
Investment income	1,761	1,982	2,982
Total operating revenue	793,544	644,161	503,855
Expenses:			
Medical care costs:			
Medical services	212,111	177,584	149,999
Hospital and specialty services	374,076	296,347	212,799
Pharmacy	71,734	56,087	45,612
Total medical care costs	657,921	530,018	408,410
Marketing, general and administrative expenses (including a charge for stock option settlements of $7,796 in 2002)	61,543	61,227	42,822
Depreciation and amortization	6,333	4,112	2,407
Total expenses	725,797	595,357	453,639
Operating income	67,747	48,804	50,216
Other income (expense):			
Interest expense	(1,452)	(438)	(347)
Other, net	118	33	(214)
Total other expense	(1,334)	(405)	(561)
Income before income taxes	66,413	48,399	49,655
Provision for income taxes	23,896	17,891	19,453
Income before minority interest	42,517	30,508	30,202
Minority interest	—	—	(73)
Net income	$ 42,517	$ 30,508	$ 30,129
Net income per share:			
Basic	$ 1.91	$ 1.53	$ 1.51
Diluted	$ 1.88	$ 1.48	$ 1.46
Weighted average shares outstanding:			
Basic	22,224,000	20,000,000	20,000,000
Diluted	22,629,000	20,609,000	20,572,000

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY
(dollars in thousands)

	Common Stock		Additional Paid-in Capital	Accumulated Other Comprehensive Income (Loss)	Retained Earnings	Treasury Stock	Total
	Outstanding	Amount					
Balance at January 1, 2001	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 investments				23			23
Total comprehensive income				23			30,152
Balance at December 31, 2001	20,000,000	5	—	—	64,754	—	64,759
Comprehensive income:							
Net income					30,508		30,508
Balance at December 31, 2002	20,000,000	5	—	—	95,262	—	95,267
Comprehensive income:							
Net income					42,517		42,517
Other comprehensive income, net of tax:							
Change in unrealized gain on investments				54			54
Total comprehensive income				54	42,517		42,571
Purchase of treasury stock	(1,201,174)					$(20,390)	(20,390)
Issuance of shares	7,590,000	21	$119,562				119,583
Repurchase and retirement of shares	(1,120,571)	(1)	(19,609)				(19,610)
Reclassification of accrued stock compensation expense to additional in paid-in capital			2,415				2,415
Stock option exercises and employee stock purchases	105,530		1,264				1,264
Tax benefit for exercise of employee stock options			222				222
Balance at December 31, 2003	25,373,785	$ 25	$103,854	$ 54	$ 137,779	$(20,390)	$221,322

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF CASH FLOWS
(dollars in thousands)

	Year ended December 31		
	2003	**2002**	**2001**
Operating activities			
Net income	$ 42,517	$ 30,508	$ 30,129
Minority interest	—	—	73
Adjustments to reconcile net income to net cash provided by operating activities:			
Depreciation and amortization	6,333	4,112	2,407
Amortization of capitalized credit facility fee	525	—	—
Deferred income taxes	(101)	(1,332)	(969)
Loss on disposal of property and equipment	—	38	416
Stock-based compensation	1,236	860	505
Changes in operating assets and liabilities:			
Receivables	(24,098)	(8,513)	11,610
Prepaid and other current assets	1,057	(2,838)	(436)
Medical claims and benefits payable	14,729	26,711	14,585
Accounts payable and accrued liabilities	(655)	1,171	1,554
Income taxes payable and receivable	4,008	(4,991)	1,478
Net cash provided by operating activities	45,551	45,726	61,352
Investing activities			
Purchase of equipment	(8,352)	(6,206)	(2,105)
Purchases of investments	(196,762)	—	—
Sales and maturities of investments	98,027	—	—
Release of statutory deposits	—	—	1,050
Other long-term liabilities	1,137	234	(486)
Advances to related parties and other assets	(3,727)	97	(1,537)
Net cash paid in purchase transactions	(8,934)	(3,250)	(1,250)
Net cash used in investing activities	(118,611)	(9,125)	(4,328)
Financing activities			
Issuance of common stock	119,583	—	—
Payment of credit facility fees	(1,887)	—	—
Borrowings under credit facility	8,500	—	—
Repayments under credit facility	(8,500)	—	—
Repayment of mortgage note	(3,350)	—	—
Principal payments on note payable	—	(51)	(59)
Purchase and retirement of common stock	(19,610)	—	—
Proceeds from exercise of stock options and employee stock purchases	1,264	—	—
Purchase of treasury stock	(20,390)	—	—
Net cash provided by (used in) financing activities	75,610	(51)	(59)
Net increase in cash and cash equivalents	2,550	36,550	56,965
Cash and cash equivalents at beginning of year	139,300	102,750	45,785
Cash and cash equivalents at end of year	$ 141,850	$ 139,300	$ 102,750
Supplemental cash flow information			
Cash paid during the year for:			
Income taxes	$ 19,989	$ 24,215	$ 18,944
Interest	$ 631	$ 352	$ 342
Schedule of non-cash investing and financing activities:			
Reclassification of accrued stock compensation expense to additional paid-in capital	$ 2,415	$ —	$ —
Tax benefit from exercise of employee stock options recorded as additional paid-in capital	$ 222	$ —	$ —
Change in unrealized gain on investments	$ 87	—	—
Deferred income taxes	(33)	—	—
Net unrealized gain on investments	$ 54	$ —	$ —
Fair value of assets acquired in purchase transactions	$ 8,934	$ 3,250	$ 1,250

See accompanying notes.

1. The Reporting Entity

Molina Healthcare, Inc. is a multi-state managed care organization that arranges for the delivery of health care services to persons eligible for Medicaid and other programs for low-income families and individuals. We were founded in 1980 as a provider organization serving the Medicaid population through a network of primary care clinics in California. In 1994, we began operating as a health maintenance organization (HMO). Our 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 re-capitalization as a result of the share exchange in the re-incorporation merger which occurred on June 26, 2003 (see Note 10—Restatement of Capital Accounts).

2. Significant Accounting Policies

Principles of Consolidation

The consolidated financial statements include the accounts of Molina Healthcare, Inc. and all majority-owned subsidiaries. All significant inter-company transactions and balances have been eliminated in consolidation.

Use of Estimates

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

Premium Revenue

Premium revenue is primarily derived from Medi-Cal/Medicaid programs and other programs for low-income individuals, which represented at least 99% of our premium revenue for each of the three years in the period ended December 31, 2003. 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, although there can be no certainty that such adjustments will not be significant in the future. Birth income is recorded during the month when services are rendered and accounted for 7% or less of total premium revenue during each of the three years in the period ended December 31, 2003.

Effective July 1, 2002, the state of Utah ceased paying us on a per member per month (risk) basis and entered into a stop loss agreement under which it pays our Utah HMO 100% of medical costs incurred plus 9%

of medical costs as an administrative fee. Additionally, if medical costs and the administrative fee are less than a predetermined amount, the Utah HMO will receive all or a portion of the resulting savings as additional revenue. Under the stop loss agreement, the Utah HMO recognizes premium revenue equal to medical costs incurred, the contracted administrative fee, and an estimate of the savings earned. Through December 31, 2003 we have recognized no revenue for estimated savings earned. To the extent, if any, that our estimates of medical costs incurred under this agreement are overstated, we will have also overstated the related revenue (equal to medical cares costs plus 9%) that we have recognized under this agreement.

Medical Care Costs

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

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

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

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 such members are qualified, the state of Washington assumes responsibility for the cost of patient care. Prior to January 1, 2003 the state assumed such responsibility on a retroactive basis, allowing the Washington HMO to recover claims payments paid on behalf of the SSI member. The Washington HMO will continue to recover claims payments paid on behalf of SSI members for periods prior to 2003. Estimated claims recoveries are reported as reductions to medical care costs and medical claims and benefits payable and are developed using actuarial methods based on historical claims recovery data.

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

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

	Year ended December 31		
	2003	2002	2001
Balances as of January 1	$ 90,811	$ 64,100	$ 49,515
Components of medical care costs related to:			
Current year	672,881	534,349	412,052
Prior years	(14,960)	(4,331)	(3,642)
Total medical care costs	657,921	530,018	408,410
Payments for medical care costs related to:			
Current year	572,845	452,712	356,032
Prior years	70,347	50,595	37,793
Total paid	643,192	503,307	393,825
Balances as of December 31	$105,540	$ 90,811	$ 64,100

Capitated Provider Insolvency

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

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

Premium Deficiency Reserves on Loss Contracts

We assess the profitability of our contracts for providing medical care services to our members and identify those contracts where current operating results or forecasts indicate probable future losses. Anticipated future premiums are compared to anticipated medical care costs, including the cost of processing claims. If the anticipated future costs exceed the premiums, a loss contract accrual is recognized. No such accrual was required as of December 31, 2003 or 2002.

Cash and Cash Equivalents

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

Investments

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

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

Our investments at December 31, 2003 consisted of the following:

	December 31, 2003			
	Cost or Amortized Cost	Gross Unrealized		Estimated Fair Value
		Gains	Losses	
U.S. Treasury and agency securities	$35,989	$ 58	$ 11	$36,036
Municipal securities	47,948	26	1	47,973
Corporate bonds	14,798	16	1	14,813
Total investment securities	$98,735	$100	$ 13	$98,822

The contractual maturities of our investments as of December 31, 2003 are summarized below.

	Amortized Cost	Estimated Fair Value
Due in one year or less	$41,927	$41,930
Due after one year through five years	56,808	56,892
Total debt securities	$98,735	$98,822

For the year ended December 31, 2003, proceeds from the sales and maturities of debt securities were $98.0 million. Gross realized gains and gross realized losses from sales of debt securities are calculated under the specific identification method and are included in investment income.

We had no available-for-sale securities at December 31, 2002. Certain available-for-sale securities, which were immaterial in value, were written off in 2001.

Receivables

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

	December 31,	
	2003	2002
California HMO	$22,082	$11,501
Utah HMO	26,465	12,624
Other HMOs	5,142	5,466
Total receivables	$53,689	$29,591

Substantially all receivables due our California HMO at December 31, 2003 and 2002, were collected in January of 2004 and 2003, respectively. Effective July 1, 2002, we entered into an agreement with the state of Utah calling for the reimbursement of the Utah HMO based upon costs incurred in serving our members. We recognize revenue in an amount equal to medical costs incurred plus an administrative fee of 9% of such costs and all or a portion of any cost savings realized, as defined in the agreement. Our Utah HMO bills the state of Utah monthly for actual paid health care claims plus administrative fees. Our receivable balance also includes amounts estimated for incurred but not reported claims, which, along with the related administrative fees, are not billable to the state of Utah until such claims are actually paid. All receivables are subject to potential retroactive adjustment by the various states in which we operate. As the amounts of all receivables are readily determinable and our creditors are state governments, we do not maintain an allowance for doubtful accounts. Any amounts determined to be uncollectible are charged to expense when such determination is made.

Restricted Investments

Pursuant to the regulations governing our subsidiaries, we maintain statutory deposits with each state as follows:

	December 31	
	2003	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 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 depreciated over its estimated useful life of 31.5 years.

Goodwill and Intangible Assets

Goodwill and intangible assets represent the excess of the purchase price over the fair value of net assets acquired. Identifiable intangible assets (consisting principally of purchased contract rights) are amortized on a straight-line basis over the expected period to be benefited. Effective January 1, 2002, we ceased amortization of goodwill in accordance with the provisions of SFAS No. 142, *Goodwill and Other Intangible Assets*. Prior to that date, we amortized goodwill over periods not exceeding 15 years. We performed the required impairment tests of goodwill and indefinite lived intangible assets in 2003 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 year ended December 31, 2001:

	Year ended December 31		
	2003	2002	2001
Net income:			
As reported	$42,517	$30,508	$30,129
Adjusted			30,428
Basic earnings per share:			
As reported	1.91	1.53	1.51
Adjusted			1.52
Diluted earnings per share:			
As reported	1.88	1.48	1.46
Adjusted			1.48

Long-Lived Asset Impairment

Situations may arise where the carrying value of a long-lived asset may exceed the present value of the expected cash flows associated with that asset. In such circumstances the asset is said to be impaired. We review material long-lived assets for impairment on an annual basis, as well as when events or changes in business conditions suggest potential impairment. Impaired assets are written down to fair value. We have determined that no long-lived assets are impaired at December 31, 2003 and 2002.

Income Taxes

We account for income taxes based on SFAS No. 109, *Accounting for Income Taxes*. SFAS No. 109 is an asset and liability approach that requires the recognition of deferred tax assets and liabilities for the expected future tax consequences of events that have been recognized in our financial statements or tax returns. Measurement of the deferred items is based on enacted tax laws. Valuation allowances are established, when necessary, to reduce future income tax assets to the amount expected to be realized.

Taxes Based on Premiums

Both our Washington and Michigan HMOs are assessed a tax based upon premium revenue collected. The Michigan premium tax was not implemented until the second quarter of 2003. Premium tax expense totaled $9,194, $4,997 and $4,028 in 2003, 2002 and 2001, respectively, and is included in marketing, general and administrative expenses.

Professional Liability Insurance

We carry medical malpractice insurance for health care services rendered through our clinics in California. Through December 31, 2003 claims-made coverage under this insurance was $5,000 per occurrence with an annual aggregate limit of $10,000. Subsequent to December 31, 2003, claims-made coverage under this insurance is $1,000 per occurrence with an annual aggregate limit of $3,000. We also carry claims-made managed care professional liability insurance for our HMO operations. This insurance is subject to a coverage limit of $5,000 per occurrence and in aggregate for each policy year. Our accruals for uninsured claims and claims incurred but not reported are reviewed by independent actuaries and are included in other long-term liabilities.

Stock-Based Compensation

At December 31, 2002, we had two stock-based employee compensation plans, which are described more fully in Note 11. We account for the plans under the recognition and measurement principles (the intrinsic-value method) prescribed in Accounting Principles Board (APB) Opinion No. 25, *Accounting for Stock Issued to Employees*, and related interpretations. Compensation cost for stock options is reflected in net income and is measured as the excess of the market price of our stock at the date of grant over the amount an employee must pay to acquire the stock. We have adopted the disclosure provisions required by SFAS No. 148, *Accounting for Stock-Based Compensation—Transition and Disclosure*.

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

	Year ended December 31		
	2003	2002	2001
Net income, as reported	$42,517	$30,508	$30,129
Reconciling items (net of related tax effects):			
Add: Stock-based employee compensation expense determined under the intrinsic-value based method for all awards	1,236	542	307
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	(1,442)	(620)	(519)
Net adjustment	(206)	4,835	(212)
Net income, as adjusted	$42,311	35,343	29,917
Earnings per share:			
Basic—as reported	$ 1.91	$ 1.53	$ 1.51
Basic—as adjusted	$ 1.90	$ 1.77	$ 1.50
Diluted—as reported	$ 1.88	$ 1.48	$ 1.46
Diluted—as adjusted	$ 1.87	$ 1.72	$ 1.45

Earnings Per Share

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

	Year ended December 31		
	2003	2002	2001
Shares outstanding at the beginning of the period	20,000,000	20,000,000	20,000,000
Weighted-average number of shares issued	3,806,000	—	—
Weighted-average number of shares acquired	(1,582,000)	—	—
Denominator for basic earnings per share	22,224,000	20,000,000	20,000,000
Dilutive effect of employee stock options(1)	405,000	609,000	572,000
Denominator for diluted earnings per share	22,629,000	20,609,000	20,572,000

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

Concentrations of Credit Risk

Financial instruments that potentially subject us to concentrations of credit risk consist primarily of cash and cash equivalents, investments, receivables and restricted investments. We invest a substantial portion of our cash in the CADRE Affinity Fund and CADRE Reserve Fund (CADRE Funds), a portfolio of highly liquid money market securities. The CADRE Funds are a series of funds managed by the CADRE Institutional Investors Trust (Trust), a Delaware business trust registered as an open-end management investment fund. Our investments (all of which are classified as current assets) and a portion of our cash equivalents are managed by three professional portfolio managers operating under documented investment guidelines. Our investments consist solely of investment grade debt securities with a maximum maturity of five years and an average duration of two years. Restricted investments are invested principally in certificates of deposit and treasury securities. Concentration of credit risk with respect to receivables is limited as the payors consist principally of state governments.

Fair Value of Financial Instruments

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

Risks and Uncertainties

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

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

Segment Information

We present segment information externally the same way management uses financial data internally to make operating decisions and assess performance. Each of our 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, we have one reportable segment.

3. Acquisitions

Michigan HMO

Through April 1999, we held a 24.05% interest in Michigan Managed Care Providers, Inc. In May 1999, we acquired the remaining 75.95% interest of Michigan Managed Care Providers, Inc. and also purchased a 62.5% interest in Good Health Michigan, Inc. for $45. These two companies were subsequently merged to form our Michigan HMO, with our California HMO owning an 81.13% interest in the combined entity. On October 30, 2001, the California HMO acquired the outstanding 18.87% minority interest for $350. We recorded total goodwill and intangible assets of $4,591 in connection with the Michigan acquisitions. On July 31, 2003, our California HMO transferred ownership of our Michigan subsidiary to us by dividend, causing our Michigan subsidiary to become our direct, wholly-owned subsidiary.

Effective August 1, 2003 approximately 9,400 members were transferred to our Michigan HMO under the terms of an agreement with another health plan. Effective October 1, 2003 approximately 32,000 members were transferred to our Michigan HMO under the terms of an agreement with yet another health plan. Total costs associated with these two transactions were $8,934. In both instances the entire cost of the transactions was recorded as an identifiable intangible asset and is being amortized over 60 months.

Washington HMO

On July 1, 2002, our Washington HMO paid $3,250 to another health plan for the assignment of a Medicaid contract. The assigned contract had a remaining term of six months on the acquisition date and was subsequently renewed for an additional one-year period as anticipated by us at the time of acquisition. The assignment was accounted for as a purchase transaction and the purchase price was allocated to an identifiable intangible asset.

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, we 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 and the purchase price was allocated to an identifiable intangible asset.

4. Property and Equipment and Intangible Assets

A summary of property and equipment is as follows:

	December 31	
	2003	2002
Land	$ 3,000	$ 3,000
Building and improvements	10,493	8,076
Furniture, equipment and automobiles	11,469	8,339
Capitalized computer software costs	3,087	893
	28,049	20,308
Less accumulated depreciation and amortization	(9,669)	(6,648)
Property and equipment, net	$18,380	$13,660

Depreciation expense recognized for the years ending December 31, 2003, 2002 and 2001 was $3,632, $2,144 and $1,986, respectively.

Goodwill and intangible assets at December 31, 2003 and 2002 were as follows:

	December 31	
	2003	2002
Goodwill	$ 4,622	$ 4,622
Contract acquisitions	13,244	4,310
	17,866	8,932
Less accumulated amortization	(5,582)	(2,881)
Goodwill and intangible assets, net	$12,284	$ 6,051

Amortization of intangibles for the years ending December 31, 2003, 2002 and 2001 was $2,701, $1,968, and $421, respectively.

The estimated aggregate amortization of intangible assets by year is estimated to be:

Year ending December 31	
2004	$ 1,787
2005	1,787
2006	1,787
2007	1,787
2008	1,295

5. Related Party Transactions

Advances to related parties are as follows:

	December 31	
	2003	2002
Note receivable due from Molina Family Trust, secured by two medical buildings, bearing interest at 7% with monthly payments due through 2026	—	$ 316
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	—	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	$2,188	1,496
	$2,188	$2,200

We lease two medical clinics from the Molina Family Trust. These leases have five five-year renewal options. In May 2001, we entered into a similar agreement with the Molina Siblings Trust for the lease of another medical clinic. The lease is for seven years with two 10-year renewal options. Rental expense for these leases totaled $383, $390 and $295 for the years ended December 31, 2003, 2002 and 2001, respectively. Minimum future lease payments consist of the following approximate amounts at December 31, 2003: $392 in 2004; $332 in 2005; $318 in 2006; $327 in 2007 and $82 in 2008.

We are a party to Collateral Assignment Split-Dollar Insurance Agreements (Agreements) with 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 shareholder, in exchange for services from Mrs. Molina.

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 through December 31, 2003 and 2002 of $3,349 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 (4% for both 2003 and 2002). Such receivables are secured by the cash surrender values of the policies.

We received architecture and technology services from companies owned by non-employee members of the Molina family. Payments for architecture services received in the year ended December 31, 2001 totaled $71. Technology services received during the years ended December 31, 2002 and 2001 totaled $86 and $59, respectively.

6. Long-Term Debt

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

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

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

7. Income Taxes

The provision for income taxes is as follows:

	Year ended December 31		
	2003	2002	2001
Current:			
Federal	$22,695	$17,387	$17,541
State	1,302	1,836	2,881
Total current	23,997	19,223	20,422
Deferred:			
Federal	14	(1,235)	(934)
State	(115)	(97)	(35)
Total deferred	(101)	(1,332)	(969)
Total provision for income taxes	$23,896	$17,891	$19,453

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

	Year ended December 31		
	2003	2002	2001
Taxes on income at statutory federal tax rate	$23,245	$16,940	$17,379
State income taxes, net of federal benefit	771	1,130	1,850
Nondeductible goodwill	—	—	104
Other	(120)	12	168
Change in valuation allowance	—	(191)	(48)
Reported income tax expense	$23,896	$17,891	$19,453

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

	December 31	
	2003	2002
Accrued expenses	$1,565	$1,599
State taxes	885	747
Shared risk	—	(302)
Other, net	(8)	39
Deferred tax asset—current	2,442	2,083
Net operating losses	272	300
Depreciation and amortization	(389)	(221)
Deferred compensation	1,655	831
Other accrued medical costs	97	1,022
Other, net	361	355
Deferred tax asset—long term	1,996	2,287
Net deferred income tax assets	$4,438	$4,370

During 2003, we pursued various strategies to reduce our federal, state and local taxes. As a result, we have reduced our state income tax expense by $1.6 million relating to California Economic Development Tax Credits (Credits). Approximately $1.0 million of the 2003 Credits relate to prior years that are being recovered through amended state tax filings. The table below includes a breakdown of the total 2003 Credits, net of recovery fees paid to consultants (included in marketing, general and administrative expenses).

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

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

8. Employee Benefits

We sponsor 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. We match up to the first 4% of compensation contributed by employees. Expense recognized in connection with our contributions to the 401(k) plan totaled $1,120, $1,007 and $737 in the years ended December 31, 2003, 2002 and 2001, respectively.

9. Commitments and Contingencies

Leases

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

Year ending December 31	
2004	$ 5,491
2005	5,016
2006	4,778
2007	4,188
2008	3,441
Thereafter	12,069
	$34,983

Rental expense related to these leases totaled $5,771, $4,930 and $4,239 for the years ended December 31, 2003, 2002 and 2001, 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. Additionally, many of our medical contracts are complex in nature and may be subject to differing interpretations regarding amounts due for the provision of various services. Such differing interpretations may lead to disputes with medical providers which may seek additional monetary compensation.

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.

Employment Agreements

Terms

During 2001 and 2002, we entered into employment agreements with five executives with initial terms of one to three years, subject to automatic one-year extensions thereafter. The agreements provide for annual base salaries of $1,882 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, we will pay one year's base salaries and Target Bonus for the year of termination, in addition to full vesting of 401(k) employer contributions and stock options, and continued health and welfare benefits for the earlier of 18 months or the date the executive receives substantially similar benefits from another employer. If any of the executives are terminated for cause, no further payments are due under the contracts.

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

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

Stock Option Settlements

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

On November 7, 2002, we agreed to acquire fully vested stock options to purchase 95,200 shares of common stock held by another executive through a cash payment of $1,023. The cash payment was determined based on the negotiated fair value per share in excess of exercise price of the 95,200 shares as if the options were exercised and the shares repurchased. The cash settlement resulted in a 2002 fourth quarter compensation charge of $916.

Regulatory Capital and Dividend Restrictions

Our principal operations are conducted through our 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 us. Our proportionate share of the net assets in these subsidiaries (after inter-company eliminations) which may not be transferable in the form of loans, advances or cash dividends was $72.0 million and $30.1 million at December 31, 2003 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, 2003, our HMOs had aggregate statutory capital and surplus of approximately $88.7 million, compared with the required minimum aggregate statutory capital and surplus of approximately $41.6 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

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

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. Our board of directors may designate the rights, preferences and privileges of each series of preferred stock at a future date. Such rights, preferences and privileges may include dividend and liquidation preferences and redemption and voting rights.

11. Stock Plans

We have made periodic grants of stock options to key employees and non-employee directors under the 2000 Omnibus Stock and Incentive Plan (the 2000 Plan) and prior grants. Pursuant to the 2000 Plan, we 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. Exercise price, vesting periods and option terms are determined by the board of directors.

During the year ended December 31, 2003 we issued options to purchase 70,000 shares of our common stock with an estimated fair value of $374. No options were issued during the year ended December 31, 2002. During the years ended December 31, 2001 we issued options to purchase 378,000 shares of our common stock with an estimated total fair value of $2,850. All options granted through July 2, 2003 vested upon the completion of our initial public offering of common stock in July of 2003. Further grants under the 2000 Plan have been frozen.

In 2002, we adopted the 2002 Equity Incentive Plan (2002 Plan), which provides for the granting of stock options, restricted stock, performance shares and stock bonus awards to the Company's officers, employees, directors, consultants, advisors and other service providers. The 2002 Plan was effective upon the effectiveness of our initial public offering of common stock in July of 2003. The 2002 Plan 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 January 1, 2004, and each year thereafter, shares eligible for issuance will automatically increase by the lesser of 400,000 shares or 2% of total outstanding capital stock on a fully diluted basis, unless the board of directors provides for a smaller increase. 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. Through December 31, 2003 no awards have been made under the 2002 Plan.

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

Through December 31, 2003, a total of 80,130 shares had been issued pursuant to the Purchase Plan.

Through June 30, 2003, 632,840 of outstanding options were granted with exercise prices below fair value. Upon the effectiveness of our initial public offering of common stock in July 2003, all outstanding options vested immediately and all deferred stock–based compensation was expensed immediately. Additionally, the liability for stock-based compensation expense was reclassified to paid-in-capital. Compensation expense recognized in the consolidated statements of income in connection with these options was $1,236, $860 and $505 during 2003, 2002 and 2001, respectively.

The fair value of the options was estimated at the grant date using the Minimum Value option-pricing model. The following assumptions were used: a risk-free interest rate of 3.78% in 2003 and 5.54% in 2001 (no options were granted in 2002); a 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 our employee stock options have characteristics significantly different from those of traded options, and because changes in the subjective input assumptions can materially affect the fair value estimate, in management's opinion, the existing models do not necessarily provide a reliable single measure of the fair value of its employee stock options.

Stock option activity and related information is as follows:

	Year ended December 31					
	2003		2002		2001	
	Options	Weighted Average Exercise Price	Options	Weighted Average Exercise Price	Options	Weighted Average Exercise Price
Outstanding at beginning of year	758,360	$ 3.57	1,498,600	$ 2.28	1,171,800	$ 1.61
Granted	70,000	16.98	—	—	378,000	4.50
Exercised	25,400	2.83	—	—	—	—
Forfeited(a)	5,760	4.50	740,240	1.11	51,200	3.13
Outstanding at end of year	797,200	4.77	758,360	3.57	1,498,600	2.28
Exercisable at end of year	797,200	4.77	416,680	2.87	995,960	1.34
Weighted average per option fair value of options granted during the year		5.35		—		7.54

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

Range of Exercise Prices	Options Outstanding			Options Exercisable	
	Number Outstanding at December 31 2003	Weighted Average Remaining Contractual Life (Number of Months)	Weighted Average Exercise Price	Number Exercisable at December 31 2003	Weighted Average Exercise Price
$2.00	237,840	70	$ 2.00	237,840	$ 2.00
3.13	47,760	76	3.13	47,760	3.13
4.50	441,600	93	4.50	441,600	4.50
16.98	70,000	110	16.98	70,000	16.98
2.00 – 16.98	797,200	87	4.77	797,200	4.77

12. Stock Transactions

Stock Repurchases

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

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

Initial Public Offering

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

13. Quarterly Results of Operations (Unaudited)

The following is a summary of the quarterly results of operations for the years ended December 31, 2003 and 2002. Dollars are in thousands except for per share data.

	For the quarter ended			
	March 31, 2003	June 30, 2003	September 30, 2003	December 31, 2003
Premium and other operating revenue	$ 191,768	$ 194,660	$ 197,053	$ 208,302
Operating income	13,349	17,594	17,593	19,211
Income before income taxes	13,275	16,990	17,227	18,921
Net income	7,980	10,947	11,724	11,866
Net income per share:				
Basic	$ 0.41	$ 0.58	$ 0.46	$ .47
Diluted	$ 0.40	$ 0.57	$ 0.46	$ .46
Period end membership	511,000	515,000	530,000	564,000

	For the quarter ended			
	March 31, 2002	June 30, 2002	September 30, 2002	December 31, 2002
Premium and other operating revenue	$ 143,852	$ 150,358	$ 172,990	$ 174,979
Operating income	8,521	13,923	19,001	7,359
Income before income taxes	8,430	13,645	19,101	7,223
Net income	5,100	8,367	12,133	4,908
Net income per share:				
Basic	$ 0.26	$ 0.42	$ 0.61	$ .25
Diluted	$ 0.25	$ 0.40	$ 0.59	$ .24
Period end membership	424,000	447,000	478,000	489,000

14. Condensed Financial Information of Registrant

Following are the condensed balance sheets of the Registrant as of December 31, 2003 and 2002, and the statements of income and cash flows for each of the three years in the period ended December 31, 2003.

Condensed Balance Sheets

	December 31	
	2003	2002
Assets		
Current assets:		
Cash and cash equivalents	$ 11,868	$ 27,597
Investments	84,733	—
Deferred income taxes	414	552
Due from affiliates	9,506	257
Prepaid and other current assets	3,714	1,862
Total current assets	110,235	30,268
Property and equipment, net	9,693	5,180
Investment in subsidiaries	101,841	65,557
Deferred income taxes	325	225
Advances to related parties and other assets	5,977	994
Total assets	$228,071	$ 102,224
Liabilities and stockholders' equity		
Current liabilities:		
Accounts payable and accrued liabilities	$ 3,146	$ 3,527
Income taxes payable	1,565	2,253
Total current liabilities	4,711	5,780
Other long-term liabilities	2,038	1,177
Total liabilities	6,749	6,957
Commitments and contingencies		
Stockholders' equity:		
Common stock, $0.001 par value; 80,000,000 shares authorized; issued and outstanding: 25,373,785 shares at December 31, 2003 and 20,000,000 shares at December 31, 2002	25	5
Preferred stock, $0.001 par value; 20,000,000 shares authorized, no shares issued and outstanding	—	—
Paid-in capital	103,854	—
Accumulated other comprehensive income, net of tax	54	—
Retained earnings	137,779	95,262
Treasury stock (1,201,174 shares, at cost)	(20,390)	—
Total stockholders' equity	221,322	95,267
Total liabilities and stockholders' equity	$228,071	$ 102,224

Condensed Statements of Income

	Year ended December 31,		
	2003	2002	2001
Revenue:			
Management fees	$41,685	$42,553	$24,817
Investment income	788	179	114
Total operating revenue	42,473	42,732	24,931
Expenses:			
Medical care costs	9,124	7,034	6,480
Marketing, general and administrative expenses (including a charge for stock option settlements of $7,796 in 2002)	24,538	29,834	15,926
Depreciation and amortization	2,669	1,095	636
Total expenses	36,331	37,963	23,042
Operating income	6,142	4,769	1,889
Other income (expense):			
Interest expense	(1,110)	(140)	(335)
Other, net	—	88	(4)
Total other expense	(1,110)	(52)	(339)
Income before income taxes and equity in net income of subsidiaries	5,032	4,717	1,550
Provision for income taxes	1,542	2,001	697
Net income before equity in net income of subsidiaries	3,490	2,716	853
Equity in net income of subsidiaries	39,027	27,792	29,276
Net income	$42,517	$30,508	$30,129

Condensed Statements of Cash Flows

	Year ended December 31		
	2003	2002	2001
Operating activities			
Cash provided by operating activities	$ 5,609	$ 2,969	$ 984
Investing activities			
Net dividends from and capital contributions to subsidiaries	2,743	26,350	2,200
Purchases of investments	(182,673)	—	—
Sales and maturities of investments	98,027	—	—
Purchases of equipment	(7,182)	(4,024)	(1,763)
Changes in amounts due to and due from affiliates	(9,249)	(1,584)	2,327
Change in other assets and liabilities	(1,964)	572	(1,062)
Net cash provided by (used in) investing activities	(100,298)	21,314	1,702
Financing activities			
Issuance of common stock	119,583	—	—
Payment of credit facility fees	(1,887)	—	—
Borrowings under credit facility	8,500	—	—
Repayments under facility	(8,500)	—	—
Purchase and retirement of common stock	(19,610)	—	—
Proceeds from exercise of stock options and employee stock purchases	1,264	—	—
Cash dividends declared	(20,390)	—	—
Net cash provided by financing activities	78,960	—	—
Net (decrease) increase in cash and cash equivalents	(15,729)	24,283	2,686
Cash and cash equivalents at beginning of year	27,597	3,314	628
Cash and cash equivalents at end of year	$ 11,868	$27,597	$ 3,314

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 2003, 2002 and 2001 for these services totaled $41,685, $42,553 and $24,817, respectively, which are included in operating revenue.

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

Note C—Capital Contribution and Dividends

During 2003, 2002 and 2001, the Registrant received dividends from its subsidiaries totaling $12,200, $31,000 and $5,900, respectively. Such amounts have been recorded as a reduction to the investments in the respective subsidiaries.

During 2003, 2002 and 2001, the Registrant made capital contributions to certain subsidiaries totaling $9,457, $4,650 and $3,700 respectively, primarily to comply with minimum net worth requirements and to fund contract acquisitions. Such amounts have been recorded as an increase in investment in the respective subsidiaries.

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

None.

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

Our Chief Executive Officer and our Chief Financial Officer have concluded, based upon their evaluation as of the end of the period covered by the report, that the Company's "disclosure controls and procedures" (as defined in Rules 13(a)-15(e) and 15d-14(e) under the Securities Exchange Act of 1934 (the "Exchange Act")) are effective to ensure that information required to be disclosed in the reports that the Company files or submits under the Exchange Act is recorded, processed, summarized and reported within the time periods specified in the Securities and Exchange Commission's rules and forms. There were no changes in the Company's internal control over financial reporting during the quarter ended December 31, 2003 that have materially affected, or are reasonably likely to materially affect, the Company's internal controls over financial reporting.

PART III

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

The information required under this Item is incorporated by reference to our definitive proxy statement pursuant to Regulation 14A to be filed with the Commission no later than 120 days after the close of our fiscal year ended December 31, 2003.

We have adopted a code of ethics that applies to our chief executive officer, chief financial officer and controller. The code of ethics is posted on our website at *www.molinahealthcare.com.*

Item 11. ***Executive Compensation***

The information required under this Item is incorporated by reference to our definitive proxy statement pursuant to Regulation 14A to be filed with the Commission no later than 120 days after the close of our fiscal year ended December 31, 2003.

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

The information required under this Item is incorporated by reference to our definitive proxy statement pursuant to Regulation 14A to be filed with the Commission no later than 120 days after the close of our fiscal year ended December 31, 2003.

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

The information required under this Item is incorporated by reference to our definitive proxy statement pursuant to Regulation 14A to be filed with the Commission no later than 120 days after the close of our fiscal year ended December 31, 2003.

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

The information required under this Item is incorporated by reference to our definitive proxy statement pursuant to Regulation 14A to be filed with the Commission no later than 120 days after the close of our fiscal year ended December 31, 2003.

PART IV

Item 15. ***Exhibits, Financial Statement Schedules, and Reports on Form 8-K***

a. *Financial Statements*

Report of Independent Auditors—Ernst & Young LLP
Consolidated Balance Sheets—At December 31, 2003 and 2002
Consolidated Statements of Operations—Years ended December 31, 2003, 2002 and 2001
Consolidated Statements of Shareholders' Equity—Years ended December 31, 2003, 2002 and 2001
Consolidated Statements of Cash Flows—Years ended December 31, 2003, 2002 and 2001
Notes to Consolidated Financial Statements

b. *Reports on Form 8-K*

The following reports on Form 8-K have been filed or furnished during the quarter ended December 31, 2003:

1. Report on Form 8-K dated October 15, 2003, announcing the addition of certain membership to our Michigan health plan.
2. Report on Form 8-K dated November 5, 2003, announcing our financial results for the quarter ended September 30, 2003 and providing certain earnings guidance.
3. Report on Form 8-K dated November 7, 2003 reconciling non-GAAP financial measures.
4. Report on Form 8-K dated December 4, 2003, announcing that our stockholders had elected two directors and ratified the selection of our independent accountants.

c. *Exhibits*

Reference is made to the Index to Exhibits.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, as amended, the undersigned registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized, on the 19th day of February, 2004.

MOLINA HEALTHCARE, INC.

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

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

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

Signature	Title	Date
/s/ J. MARIO MOLINA, M.D. **J. Mario Molina, M.D.**	Director, Chairman of the Board, Chief Executive Officer and President (Principal Executive Officer)	February 19, 2004
/s/ JOHN C. MOLINA, J.D. **John C. Molina, J.D.**	Director, Executive Vice President, Financial Affairs, Chief Financial Officer and Treasurer (Principal Financial Officer)	February 19, 2004
/s/ JOSEPH W. WHITE, CPA **Joseph W. White, CPA**	Vice President, Accounting (Principal Accounting Officer)	February 19, 2004
/s/ GEORGE S. GOLDSTEIN, PH.D. **George S. Goldstein, Ph.D.**	Director; Executive Vice President, Health Plan Operations	February 19, 2004
/s/ RONALD LOSSETT, CPA, D.B.A **Ronald Lossett, CPA, D.B.A**	Director	February 19, 2004
/s/ CHARLES Z. FEDAK, CPA **Charles Z. Fedak, CPA**	Director	February 19, 2004
/s/ SALLY K. RICHARDSON **Sally K. Richardson**	Director	February 19, 2004

INDEX TO EXHIBITS

Exhibit Number	Description of Exhibit
3.1	Certificate of Incorporation (incorporated by reference to Exhibit 3.2 to registrant's Registration Statement on Form S-1 (Number 333-102268), as amended).
3.2	Amended and Restated Bylaws (incorporated by reference to Exhibit 3.4 to registrant's Current Report on Form 8-K, filed September 23, 2003 (Number 1-31719)).
3.3	Form of share certificate for common stock (incorporated by reference to Exhibit 3.5 to registrant's Registration Statement on Form S-1 (Number 333-102268), as amended).
10.1	Medi-Cal Agreement between Molina Medical Centers and the California Department of Health Services dated April 2, 1996, as amended.
10.2*	Health Services Agreement between Foundation Health, and Molina Medical Centers dated February 1, 1996, as amended (incorporated by reference to Exhibit 10.2 to registrant's Registration Statement on Form S-1 (Number 333-102268), as amended).
10.3	Contract Between Molina Healthcare of Michigan, Inc. and the State of Michigan effective October 1, 2000, as amended.
10.4*	HMO Contract between American Family Care and the Utah Department of Health effective July 1, 1999, as amended (incorporated by reference to Exhibit 10.4 to registrant's Registration Statement on Form S-1 (Number 333-102268), as amended).
10.5*	Memorandum of Understanding between Molina Healthcare of Utah, Inc. and the Utah Department of Public Health effective July 1, 2002 (incorporated by reference to Exhibit 10.5 to registrant's Registration Statement on Form S-1 (Number 333-102268), as amended).
10.6	2003-2005 Contract for Healthy Options and State Children's Health Insurance Plan between Molina Healthcare of Washington, Inc. and the State of Washington Department of Social and Health Services effective January 1, 2002, as amended.
10.7	Employment Agreement with J. Mario Molina, M.D. dated January 2, 2002 (incorporated by reference to Exhibit 10.7 to registrant's Registration Statement on Form S-1 (Number 333-102268), as amended).
10.8	Employment Agreement with John C. Molina, J.D. dated January 1, 2002 (incorporated by reference to Exhibit 10.8 to registrant's Registration Statement on Form S-1 (Number 333-102268), as amended).
10.9	Employment Agreement with Mark L. Andrews, Esq. dated December 1, 2001 (incorporated by reference to Exhibit 10.9 to registrant's Registration Statement on Form S-1 (Number 333-102268), as amended).
10.10	Employment Agreement with George S. Goldstein, PhD. dated July 30, 1999 (incorporated by reference to Exhibit 10.10 to registrant's Registration Statement on Form S-1 (Number 333-102268), as amended).
10.11	Employment Agreement with M. Martha Bernadett, M.D. dated January 1, 2002 (incorporated by reference to Exhibit 10.11 to registrant's Registration Statement on Form S-1 (Number 333-102268), as amended).
10.12	2000 Omnibus Stock and Incentive Plan (incorporated by reference to Exhibit 10.12 to registrant's Registration Statement on Form S-1 (Number 333-102268), as amended).
10.13	2002 Equity Incentive Plan (incorporated by reference to Exhibit 10.13 to registrant's Registration Statement on Form S-1 (Number 333-102268), as amended).

Exhibit Number	Description of Exhibit
10.14	2002 Employee Stock Purchase Plan (incorporated by reference to Exhibit 10.14 to registrant's Registration Statement on Form S-1 (Number 333-102268), as amended).
10.15	Credit Agreement dated as of March 19, 2003 (incorporated by reference to Exhibit 10.15 to registrant's Registration Statement on Form S-1 (Number 333-102268), as amended).
10.16*	Amendment to Health Services Agreement effective October 1, 2002 between Foundation Health and Molina Medical Centers dated February 1, 1996, as amended (incorporated by reference to Exhibit 10.18 to registrant's Registration Statement on Form S-1 (Number 333-102268), as amended).
10.17*	Amendment to Health Services Agreement effective October 1, 2002 between Foundation Health and Molina Medical Centers dated February 1, 1996, as amended (incorporated by reference to Exhibit 10.19 to registrant's Registration Statement on Form S-1 (Number 333-102268), as amended).
10.18	Amendment to Health Services Agreement effective October 28, 2003 between Foundation Health and Molina Medical Centers dated February 1, 1996, as amended.
21.1	Subsidiaries (incorporated by reference to Exhibit 21.1 to registrant's Registration Statement on Form S-1 (Number 333-102268), as amended).
23.1	Consent of Ernst & Young LLP, Independent Auditor.
31.1	Certificate of Chief Executive Officer pursuant to Rules 13a-14(a)/15d-14(a) under the Securities Exchange Act of 1934, as amended.
31.2	Certificate of Chief Financial Officer pursuant to Rules 13a-14(a)/15d-14(a) under the Securities Exchange Act of 1934, as amended.
32.1	Certificate of Chief Executive Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
32.2	Certificate of Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.

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

EXHIBIT 10.1

STATE OF CALIFORNIA • HEALTH AND HUMAN SERVICES AGENCY GRAY DAVIS, *Governor*

DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
P.O. BOX 942732
SACRAMENTO, CA 94234-7320

[STAMP]

CONTRACTOR NOTICE/INSTRUCTIONS

CONTRACTOR: Molina Healthcare of California

CONTRACT NUMBER: 95-23637 A11

Inquiries about this notice must reference the contract number above and be directed to the Department of Health Services' (DHS) Contract Management Unit (CMU) at (916): 650-0100

To complete the processing of your contract, follow all instructions checked ☒ below:

☐ Affix an original signature to each enclosed contract copy/face sheet. Retain one full contract copy. Return, to CMU's address below, any remaining contract copies/face sheets, along with any additional items being requested, as indicated by a check mark ☒.

☒ Enclosed for your records is your fully executed contract copy. Include DHS's contract number on all invoices and future correspondence related to this contract.

☐ The enclosed contract has been fully approved by the State. Upon affixing your signature, the contract will be fully executed. Retain a full contract copy. Sign/turn, to CMU's address below, any remaining contract copies/face sheets for final distribution.

☐ The enclosed agreement has been signed by DHS. When fully executed, return one originally signed copy and any extra copies to CMU's address below. Include DHS's contract number on future correspondence related to this contract.

☐ Complete, sign, and return the enclosed Vendor Data Record form.

☐ Return two copies of Board Motion/Resolution.

☐ Other:

Return all items requested above to CMU at the following address:

DHS Contract Management Unit
1501 Capitol Avenue, Suite 71.2101
MS 1403
P.O. Box 99741
Sacramento, CA 95899-7413

Please do not alter the enclosed contract. Until the contract is fully executed and distributed, no costs are reimbursable.

For program matters, invoice issues, or to request contract alterations, contact:

DHS Policy & Contracts
Attn: Christina Rodriguez-Moreno (916) 449-5094
1501 Capitol Ave, P.O. Box 942732, MS 4407
Sacramento, CA 95814

Enclosures

STATE OF CALIFORNIA
STANDARD AGREEMENT AMENDMENT
_____DHS Rev 6/03)

☒ CHECK HERE IF ADDITIONAL PAGES ARE ADDED **229** PAGES

AGREEMENT NUMBER **95-23637** AMENDMENT NUMBER **11**

REGISTRATION NUMBER: 4260100314078

1. This Agreement is entered into between the State Agency and Contractor named below:

STATE AGENCY'S NAME (Also referred to as CDHS, DHS, or the State)

California Department of Health Services

CONTRACTOR'S NAME (Also referred to as Contractor)

Molina Healthcare of California, dba: Molina

2. The term of this Agreement is **4/02/96** through **3/31/04**

3. The maximum amount of this Agreement is: **$____**

4. The parties mutually agree to this amendment as follows. All actions noted below are by this reference made a part of the Agreement and incorporated herein:

I. Amendment effective date: August 1, 2003

II. Purpose of amendment: The purpose of this amendment is to revise the existing contract format into the current Department of General Services recommended format, modify the substance of the contract to conform to the Federal Balanced Budget Act regulations effective August 13, 2003, and as a result, have this amendment replace all prior versions of the existing contract and any amendments thereto which predate this amendment.

All other terms and conditions shall remain the same.

IN WITNESS WHEREOF, this Agreement has been executed by the parties hereto.

CONTRACTOR

CONTRACTOR'S NAME *(If other than an individual, state whether a corporation, partnership, etc.)*
Molina Healthcare of California, dba: Molina

BY *(Authorized Signature)*
/s/ Trisha Dinsmore-Jennings

DATE SIGNED *(Do not type)*
10/13/03

PRINTED NAME AND TITLE OF PERSON SIGNING
Trisha Dinsmore-Jennings, President/C.O.O

ADDRESS
One Golden Shore Drive Long Beach, CA 90802

STATE OF CALIFORNIA

AGENCY NAME
California Department of Health Services

BY *(Authorized Signature)*
/s/ Terri L. Anderson

DATE SIGNED *(Do not type)*
10-16-03

PRINTED NAME AND TITLE OF PERSON SIGNING
Edward Stahlberg, Chief, Program Support Branch

Terri L. Anderson. Chief
Contract & Business Services Section

ADDRESS
1501 Capitol Avenue, Room 71.2101, MS 1403, P.O. Box 942732 Sacramento, CA 94234-7320

CALIFORNIA
Department of General Services
Use Only

☒ Exempt per: W & I Code 14087.4

Exhibit A
Scope of Work

1. Contractor agrees to provide to the Department of Health Services (DHS) the services described herein:

   Provide health care services to eligible Medi-Cal recipients within the scope of Medi-Cal benefits as defined in the contents of the contract.

2. The services shall be performed at all contracting and participating facilities of the Contractor.

3. The services shall be provided on a 24-hour, seven days a week basis.

4. The project representatives during the term of this agreement will be:

Department of Health Services	**Contractor**
Medi-Cal Managed Care Division Attention: Chief, Plan Management Branch Telephone: (916) 449-5100, (916) 449-5101 Fax: (916) 449-5090, (916) 449-5091	Name of Contractor's Representative: Trisha Dinsmore-Jennings, President & CEO Telephone: (562) 435-3666, ext. 7019 Fax: (562) 951-1500

Direct all inquiries to:

Department of Health Services	**Contractor**
Medi-Cal Managed Care Division Attention: Contracting Officer 1501 Capitol Avenue, Suite 71.4001 P.O. Box Number 942732, Mail Stop 4407 Sacramento, CA 94814-7320 Telephone: (916) 449-5000 Fax: (916) 449-5005	Attention: Maria Calderon, Contract Manager One Golden Shore Long Beach, CA 90802 Telephone: (562) 435-3666, ext. 7519 Fax: (562) 951-1500

Either party may make changes to the information above by giving written notice to the other party. Said changes shall not require an amendment to this agreement.

5. The following Attachments 1 through 17 are incorporated herein and made a part hereof by this reference:

   Attachment 1- Organization and Administration of the Plan

Exhibit A
Scope of Work

Attachment 2 - Financial Information
Attachment 3 - Management Information System
Attachment 4 - Quality Improvement System
Attachment 5 - Utilization Management
Attachment 6 - Provider Network
Attachment 7 - Provider Relations
Attachment 8 - Provider Compensation Arrangements
Attachment 9 - Access and Availability
Attachment 10 - Scope of Services
Attachment 11 - Case Management and Coordination of Care
Attachment 12 - Local Health Department Coordination
Attachment 13 - Member Services
Attachment 14 - Member Grievance System
Attachment 15 - Marketing
Attachment 16 - Enrollments and Disenrollments
Attachment 17 - Reporting Requirements

ORGANIZATION AND ADMINISTRATION OF THE PLAN

1. Legal Capacity

Contractor shall maintain the legal capacity to contract with DHS and maintain appropriate licensure as a health care service plan in accordance with the Knox-Keene Health Care Service Plan Act of 1975 as amended.

2. Key Personnel (Disclosure Form)

A. Contractor shall file an annual statement with DHS disclosing any purchases or leases of services, equipment, supplies, or real property from an entity in which any of the following persons have a substantial financial interest:

1) Any person also having a substantial financial interest in the Contractor.

2) Any director, officer, partner, trustee, or employee of the Contractor.

3) Any Member of the immediate family of any person designated in 1) or 2) above.

B. Comply with federal regulations 42 CFR 455.104 (Disclosure by providers and fiscal agents: Information on ownership and control), 42 CFR 455.105 (Disclosure by providers: Information related to business transactions), 42 CFR 455.106 and 42 CFR 438.610 (Prohibited Affiliations with Individuals Debarred by Federal Agencies).

3. Conflict Of Interest – Current And Former State Employees

A. This Contract shall be governed by the Conflict of Interest provisions of Title 22, CCR, Sections 53874 and 53600.

B. Contractor shall not utilize in the performance of this Contract any State officer or employee in the State civil service or other appointed State official unless the employment, activity, or enterprise is required as a condition of the officer's or employee's regular state employment. For purposes of this subsection (B) only, employee in the State civil service is defined to be any person legally holding a permanent or intermittent position in the State civil service.

4. Contract Performance

Contractor shall maintain the organization and staffing for implementing and operating the Contract in accordance with Title 28, CCR, Section 1300.67.3 and Title 22, CCR, Section 53800, 53851 and 53857. Contractor shall ensure the following:

A. The organization has an accountable governing body.

B. This Contract is a high priority and that the Contractor is committed to supplying any necessary resources to assure full performance of the Contract.

C. If the Contractor is a subsidiary organization, the attestation of the parent organization that this Contract will be a high priority to the parent organization. The parent organization is committed to supplying any necessary resources to assure full performance of the Contract.

D. Staffing in medical and other health services, and in fiscal and administrative services sufficient to result in the effective conduct of the plan's business.

E. Written procedures for the conduct of the business of the plan, including the provision of heath care services, so as to provide effective controls.

5. Medical Decisions

Contractor shall ensure that medical decisions, including those by subcontractors and rendering providers, are not unduly influenced by fiscal and administrative management.

6. Medical Director

Contractor shall maintain a full time Physician as Medical Director pursuant to Title 22, CCR, Section 53857 whose responsibilities shall include, but not be limited to, the following:

A. Ensuring that medical decisions are:

1) Rendered by qualified medical personnel.

2) Are not influenced by fiscal or administrative management considerations.

B. Ensuring that the medical care provided meets the standards for acceptable medical care.

C. Ensuring that medical protocols and rules of conduct for plan medical personnel are followed.

D. Developing and implementing medical policy.

E. Resolving grievances related to medical quality of care.

F. Direct involvement in the implementation of Quality Improvement activities.

G. Actively participating in the functioning of the plan grievance procedures.

7. Medical Director Changes

Contractor shall report to DHS any changes in the status of the Medical Director within ten (10) days.

8. Administrative Duties/Responsibilities

Contractor shall maintain the organizational and administrative capabilities to carry out its duties and responsibilities under the Contract. This will include at a minimum the following:

A. Designated persons, qualified by training or experience, to be responsible for the Medical Record service.

B. Member and Enrollment reporting systems as specified in Exhibit A, Attachment 3, Management Information System, and, Exhibit A, Attachment 13, Member Services, and Exhibit A, Attachment 14, Member Grievance System.

C. A Member grievance procedure, as specified in Exhibit A, Attachment 14, Member Grievance System.

D. Data reporting capabilities sufficient to provide necessary and timely reports to DHS, as required by Exhibit A, Attachment 3, Management Information System.

E. Financial records and books of account maintained on the accrual basis, in accordance with Generally Accepted Accounting Principles, which fully disclose the disposition of all Medi-Cal program funds received, as specified in Exhibit A, Attachment 2. Financial Information.

F. Claims processing capabilities as described in Exhibit A, Attachment 8, Provider Compensation Arrangements.

9. Member Representation

Contractor shall ensure that Medi-Cal Members are represented and participate in establishing public policy within the plan's Public Policy Advisory Committee.

FINANCIAL INFORMATION

1. Financial Viability/Standards Compliance

Contractor shall meet and maintain financial viability/standards compliance to DHS' satisfaction for each of the following elements:

A. Tangible Net Equity (TNE).

Contractor at all times shall be in compliance with the TNE requirements in accordance with Title 28, CCR, Section 1300.76.

B. Administrative Costs.

Contractor's Administrative Costs shall not exceed the guidelines as established under Title 22, CCR, Section 53864(b).

C. Standards of Organization and Financial Soundness.

Contractor shall maintain an organizational structure sufficient to conduct the proposed operations and ensure that its financial resources are sufficient for sound business operations in accordance with Title 28, CCR, Sections 1300.67.3, 1300.75.1, 1300.76.3, 1300.77.1, 1300.77.2, 1300.77.3, 1300.77.4, and Title 22, CCR, Sections 53851, 53863, and 53864.

D. Working capital and current ratio of one of the following:

1) Contractor shall maintain a working capital ratio of at least 1:1; or

2) Contractor shall demonstrate to DHS that Contractor is now meeting financial obligations on a timely basis and has been doing so for at least the preceding two years; or

3) Contractor shall provide evidence that sufficient noncurrent assets, which are readily convertible to cash, are available to achieve an equivalent working capital ratio of 1:1, if the noncurrent assets are considered current.

2. Financial Audit Reports

Contractor shall ensure that an annual audit is performed according to Welfare & Institution Code, Section 14459. Combined Financial Statements shall be prepared to show the financial position of the overall related health care delivery system when delivery of care or other services is dependent upon Affiliates.

Financial Statements shall be presented in a form that clearly shows the financial position of Contractor separately from the combined totals. Inter-entity transactions and profits shall be eliminated if combined statements are prepared. If an independent accountant decides that preparation of combined statements is inappropriate, Contractor shall have separate certified Financial Statements prepared for each entity.

A. The independent accountant shall state in writing reasons for not preparing combined Financial Statements.

B. Contractor shall provide supplemental schedules that clearly reflect all inter-entity transactions and eliminations necessary to enable DHS to analyze the overall financial status of the entire health care delivery system.

1) In addition to annual certified Financial Statements, Contractor shall complete the State Department of Managed Health Care (DMHC) required financial reporting forms. The Certified Public Accountant's audited Financial Statements and the DMHC required financial reporting forms shall be submitted to DHS no later than 120 calendar days after the close of Contractor's Fiscal Year.

2) Contractor shall submit to DHS within forty-five (45) calendar days after the close of Contractor's fiscal quarterly financial reports required by Title 22, CCR, Section 53862(b)(1). The required quarterly financial reports shall be prepared on the DMHC required financial reporting forms and shall include, at a minimum, the following reports/schedules:

a) Jurat.

b) Report 1A and 1B: Balance Sheet.

c) Report 2: Statement of Revenue, Expenses, and Net Worth.

d) Statement of Cash Flow, prepared in accordance with Financial Accounting Standards Board Statement Number 95 (This statement is prepared in lieu of Report #3: Statement of Changes in Financial Position for Generally Accepted Accounting Principles (GAAP) compliance.)

e) Report 4: Enrollment and Utilization Table.

f) Schedule F: Unpaid Claims Analysis.

g) Appropriate footnote disclosures in accordance with GAAP.

C. Contractor shall authorize its independent accountant to allow DHS designated representatives or agents, upon written request, to inspect any and all working papers related to the preparation of the audit report.

D. Contractor shall submit to DHS all financial reports relevant to Affiliates as specified in Title 22, CCR, Section 53862(c)(4).

E. Contractor shall submit to DHS copies of any financial reports submitted to other public or private organizations as specified in Title 22, CCR, Section 53862(c)(5).

3. Monthly Financial Statements

Contractor may be required to file monthly Financial Statements at DHS' request. If the Contractor is required to file monthly Financial Statements with the DMHC, Contractor shall file monthly Financial Statements with DHS.

4. Compliance with Audit Requirements

Contractor shall cooperate with DHS' audits. Such audits may be waived upon submission of the financial audit for the same period conducted by DMHC pursuant to Section 1382 of the Health and Safety Code.

5. Submittal of Financial Information

Contractor shall prepare financial information requested in accordance with GAAP and where Financial Statements/projections are requested, these statements/projections should be prepared in accordance with the 1989 HMO Financial Report of Affairs and Conditions Format. Where appropriate, reference has been made to the Knox-Keene Health Care Service Plan Act of 1975 Rules found under Title 28, CCR, Section 1300.51 et. seq. Information submitted shall be based on current operations. Contractor and/or sub-contractors shall submit financial information consistent with filing requirements of the DMHC unless otherwise specified by DHS.

MANAGEMENT INFORMATION SYSTEM

1. MIS Capability

A. Contractor's MIS shall have the capability to capture, edit, and utilize various data elements for both internal management use as well as to meet the data quality and timeliness requirements of DHS's encounter data submission. Contractor shall have and maintain a MIS that provides, at a minimum,

1) All Medi-Cal eligibility data,

2) Information of Members enrolled in Contractor's plan,

3) Provider claims status and payment data,

4) Health care services delivery encounter data,

5) Provider network information, and

6) Financial information as specified in Exhibit A, Attachment 1, regarding Administrative Duties/Responsibilities.

B. Contractor's MIS shall have processes that support the interactions between Financial, Member/Eligibility; Provider; Encounter Claims; Quality Management/Quality Improvement/Utilization; and Report Generation subsystems. The interactions of the subsystems must be compatible, efficient and successful.

2. Encounter Data Submittal

Contractor shall implement policies and procedures for ensuring the complete, accurate, and timely submission of encounter data for all services for which Contractor has incurred any financial liability, whether directly or through subcontracts or other arrangements. Encounter data shall include data elements specified in DHS' most recent Managed Care Data Element Dictionary and all existing Policy Letters related to encounter data reporting.

Contractor shall require subcontractors and non-contracting providers to provide service level data to Contractor, which allows the Contractor to meet their administrative functions and the requirements set forth in this section. Contractor shall have in place mechanisms, including edits and reporting systems sufficient to assure service level data is complete and accurate prior to submission to DHS.

Contractor shall submit encounter data to DHS on a monthly basis in the form and manner specified in DHS' most recent Managed Care Data Element Dictionary and all existing Policy Letters related to encounter data reporting.

Upon written notice by DHS that the encounter data is insufficient or inaccurate, Contractor shall ensure that corrected data is resubmitted within fifteen (15) days of receipt of DHS' notice. Upon Contractor's written request, DHS may provide a written extension for submission of corrected encounter data.

3. MIS/Data Correspondence

Upon receipt of written notice by DHS of any problems related to the submittal of data to DHS, or any changes or clarifications related to Contractor's MIS system, Contractor shall submit to DHS a Corrective Action Plan with measurable benchmarks within thirty (30) calendar days from the date of the postmark of DHS' written notice to Contractor. Within thirty (30) days of DHS' receipt of Contractor's Corrective Action Plan, DHS shall approve the Corrective Action Plan or request revisions. Within fifteen (15) days after receipt of a request for revisions to the Corrective Action Plan, Contractor shall submit a revised Corrective Action Plan for DHS approval.

4. Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Contractor shall comply with Exhibit G, Health Insurance Portability and Accountability Act of 1996 (HIPAA) requirements and all federal and State regulations promulgated from this Act, as they become effective.

QUALITY IMPROVEMENT SYSTEM

1. General Requirement

Contractor shall implement an effective Quality Improvement System (QIS) in accordance with the standards in Title 28, CCR, Section 1300.70. Contractor shall monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers rendering services on its behalf, in any setting. Contractor shall be accountable for the quality of all Covered Services regardless of the number of contracting and subcontracting layers between Contractor and the provider.

2. Accountability

Contractor shall maintain a system of accountability which includes the participation of the governing body of the Contractor's organization, the designation of a quality improvement committee with oversight and performance responsibility, the supervision of activities by the medical director, and the inclusion of contracted Physicians and other providers in the process of QIS development and performance review.

3. Governing Body

Contractor shall implement and maintain policies that specify the responsibilities of the governing body including at a minimum the following:

1) Approves the overall QIS and the annual report of the QIS.
2) Appoints an accountable entity or entities within Contractor's organization to provide oversight of the QIS.
3) Routinely receives written progress reports from the quality improvement committee describing actions taken, progress in meeting QIS objectives, and improvements made.
4) Directs the operational QIS to be modified on an ongoing basis, and tracks all review findings for follow-up.

4. Quality Improvement Committee

Contractor shall implement and maintain a Quality Improvement Committee designated by, and accountable to the governing body and shall be facilitated by the medical director or a physician designee. Contractor must ensure that subcontractors, who are representative of the composition of the contracted provider network, shall actively participate on the committee.

The committee shall meet at least quarterly but as frequently as necessary to demonstrate follow-up on all findings and required actions. The activities, findings, recommendations, and actions of the committee shall be reported to the governing body in writing on a scheduled basis.

Contractor shall maintain minutes of committee meetings and minutes shall be submitted to DHS quarterly. Contractor shall maintain a process to ensure confidentiality of quality improvement discussions as well as avoidance of conflict of interest on the part of committee members.

5. Provider Participation

Contractor shall ensure that subcontracting Physicians and other providers from the community shall be involved as an integral part of the QIS. Contractor shall maintain and implement appropriate procedures to keep subcontracting providers informed of the written QIS, its activities, and outcomes.

6. Delegation of Quality Improvement Activities

A. Contractor is accountable for all quality improvement functions and responsibilities (e.g. Utilization Management, Credentialing and Site Review) that are delegated to subcontractors. If Contractor delegates quality improvement functions, Contractor and delegated entity (subcontractor) shall include in their subcontract, at minimum:

1) Quality improvement responsibilities, and specific delegated functions and activities of the Contractor and subcontractor.

2) Contractor's oversight, monitoring, and evaluation processes and subcontractor's agreement to such processes.

3) Contractor's reporting requirements and approval processes. The agreement shall include subcontractor's responsibility to report findings and actions taken as a result of the quality improvement activities at least quarterly.

4) Contractor's actions/remedies if subcontractor's obligations are not met.

B. Contractor shall maintain a system to ensure accountability for delegated quality improvement activities, that at a minimum:

1) Evaluates subcontractor's ability to perform the delegated activities including an initial review to assure that the subcontractor has the

administrative capacity, task experience, and budgetary resources to fulfill its responsibilities.

2) Ensures subcontractor meets standards set forth by the Contractor and DHS.

3) Includes the continuous monitoring, evaluation and approval of the delegated functions.

7. Written Description

Contractor shall implement and maintain a written description of its QIS that shall include the following:

A. Organizational commitment to the delivery of quality health care services as evidenced by goals and objectives which are approved by Contractor's governing body and periodically evaluated and updated.

B. Organizational chart showing the key staff and the committees and bodies responsible for quality improvement activities including reporting relationships of QIS committee(s) and staff within the Contractor's organization.

C. Qualifications of staff responsible for quality improvement studies and activities, including education, experience and training.

D. A description of the system for provider review of QIS findings, which at a minimum, demonstrates physician and other appropriate professional involvement and includes provisions for providing feedback to staff and providers, regarding QIS study outcomes.

E. The role, structure, function of the quality improvement committee.

F. The processes and procedures that will ensure that all medically necessary health care services are available and accessible to all Members regardless of race, color, national origin, gender or disability, and that all services are provided in a culturally and linguistically appropriate manner.

G. A description of the mechanisms used to continuously review, evaluate, and improve access to and availability of services. The description shall include methods to ensure that members are able to obtain appointments within established standards.

H. Description of the quality of clinical care services provided, including, but not limited to, preventive services for children and adults, perinatal care, primary care, specialty, emergency, inpatient, and ancillary care services.

I. Description of the activities designed to assure the provision of case management, coordination and continuity of care services.

8. Quality Improvement Annual Report

Contractor shall develop an annual quality improvement report for submission to DHS on an annual basis. The annual report shall include:

A. A comprehensive assessment of the quality improvement activities undertaken and an evaluation of areas of success and needed improvements in services rendered within the quality improvement program, including but not limited to, the collection of aggregate data on utilization; the review of quality of services rendered; the results of the External Accountability Set measures; and, outcomes/findings from Quality Improvement Projects (QIPs), consumer satisfaction surveys and collaborative initiatives.

B. An assessment of subcontractor's performance of delegated quality improvement activities.

9. External Quality Review Requirements

At least annually or as designated by DHS, DHS shall arrange for an external quality of care review of the Contractor by an entity qualified to conduct such reviews in accordance with Title 22, CCR, Section 53860 (d) and Title 42, USC, Section 1396a(30)(C). Contractor shall cooperate with and assist the External Quality Review Organization (EQRO) designated by the State in the conduct of this review.

A. External Accountability Set (EAS) Performance Measures

The External Accountability Set (EAS) consists of a set of Health Plan Employer Data and Information Set (HEDIS®) measures developed by the National Committee for Quality Assurance (NCQA) and DHS developed performance measures selected by DHS for evaluation of health plan performance.

1) On an annual basis, Contractor shall submit to an on-site EAS Compliance Audit (also referred to as the Health Plan Employer Data and Information Set (HEDIS®) Compliance Audit™) to assess the Contractor's information and reporting systems, as well as the

Contractor's methodologies for calculating performance measure rates. Contractor shall use the DHS-selected contractor for performance of the EAS/HEDIS Compliance Audit and calculation of DHS-developed performance measures that constitute the EAS. Compliance Audits will be performed by an EQRO as contracted and paid for by the State.

2) Contractor shall calculate and report all EAS performance measures at the county level.

   a) HEDIS rates are to be calculated by the Contractor and verified by the DHS-selected EQRO. Rates for DHS- developed performance measures will be calculated by the EQRO.

   b) Contractor shall report audited results on the EAS performance measures to DHS no later than June 15 of each year or such date as established by DHS. Contractor shall initiate reporting on EAS performance measures for the reporting cycle following the first year of operation.

3) Contractor shall meet or exceed the DHS-established Minimum Performance Level (MPL) for each HEDIS measure.

   a) For each measure that does not meet the MPL set for that year, or is reported as a "Not Report" (NR) due to an audit failure, Contractor must submit a plan outlining the steps that will be taken to improve the subsequent year's performance.

      i. The improvement plan must include, at a minimum, identification of the team that will address the problem, a root cause analysis, identification of interventions that will be implemented, and a proposed timeline.

      ii. Improvement plans are due to the DHS within 60 calendar days of the DHS' notification that the Contractor has performed at or below the MPL for the period under review.

      iii. Additional reporting may be required of the Contractor until such time as improvement is demonstrated.

B. Under/Over-Utilization Monitoring

In addition to the EAS performance measures, Contractor shall submit to an audit of, and report rates for, an Under/Over-Utilization Monitoring Measure Set based upon selected HEDIS Use of Service measures. These measures will be audited as part of the EAS/HEDIS Compliance Audit and rates shall be submitted with the EAS audited rates. DHS will bear the costs associated with the Compliance Audit as performed by the contracted EQRO. The measures selected for inclusion in the set will be chosen by DHS on an annual basis. By August 1 of each year, DHS will notify Contractors of the HEDIS measures selected for inclusion in the following year's Utilization Monitoring measure set.

C. Quality Improvement Projects (QIPs)

Contractor is required to conduct and/or participate in four (4) Quality Improvement Projects. For Contractors holding multiple Medi-Cal managed care contracts, each contracted entity will be required to conduct and/or participate in four QIPs.

1) Among the four QIPs:

a) One must be plan-specific ("internal QIP")

b) One must be in collaboration with at least one other health plan ("small -group collaborative")

Collaboratives must include a minimum of two (2) DHS health plan Contractors and must use standardized measures and clinical practice guidelines. Additionally, all health plans participating in a collaborative must agree to the same timelines for development, implementation, and measurement. Health plans must also agree on the nature of health plan commitment of staff and other resources to the collaborative project.

Contractors may include only one county in a collaborative regardless of whether the health plan's contract covers multiple counties. However, if multiple counties are to be included, Contractor shall demonstrate that the measurement strategies are adequate to assess the impact of the intervention within each county. DHS must approve the Contractor's proposal before the Contractor proceeds with their intended approach for multiple county measurement.

c) One must be the statewide collaborative QIP ("Cal-QIP")

2) Among the above listed four QIPs:

a) One must be non-clinical (i.e., availability, accessibility or cultural competency of services; appeals, grievances, and complaints); and

b) One must be clinical (i.e., to improve clinical services or clinical interventions).

3) Contractor shall use the NCQA Quality Improvement Activity form to propose initiation of the study and for subsequent periodic reporting.

D. Consumer Satisfaction Survey

At intervals as determined by DHS, DHS' contracted EQRO will conduct a consumer satisfaction survey. Contractor shall provide appropriate data to the EQRO to facilitate this survey.

10. Site Review

A. General Requirement

Contractor shall conduct site reviews on all Primary Care Provider sites according to the Site Review Policy Letter, MMCD Policy Letter 02-02 and Title 22, CCR, Section 53856.

B. Pre-Operational Site Reviews

The number of site reviews to be completed prior to initiating plan operation in a Service Area shall be based upon the total number of new primary care sites in the provider network. For more than 30 sites in the provider network, a 5% sample size or a minimum of 30 sites, which ever is greater in number, shall be reviewed 6 weeks prior to plan operation. Reviews shall be completed on all remaining sites within six (6) months of Plan operation. For 30 or fewer sites, reviews shall be completed on all sites six (6) weeks prior to Plan operation.

C. Credentialing Site Review

A site review is required as part of the credentialing process when both the facility and the provider are added to the Contractor's provider

network. If a provider is added to Contractor's provider network, and the provider site has a current passing site review survey score, a site survey need not be repeated for provider credentialing or recredentialing.

D. Corrective Actions

Contractor shall ensure that a corrective action plan is developed to correct cited deficiencies and that corrections are completed and verified within the established guidelines as specified in MMCD Policy Letter 02-02, the Site Review Policy Letter. Primary Care Provider sites that do not correct cited differences are to be terminated from Contractor network.

E. Data Submission

Contractor shall submit the site review data to DHS by January 31 and July 31 of each year. All data elements defined by DHS shall be included in the data submission report.

F. Continuing Oversight

Contractor shall retain accountability for all site review activities whether carried out by the Contractor, completed by other Medi-Cal Managed Care contractors or delegated to other entities.

11. Disease Surveillance

Contractor shall implement and maintain procedures for reporting any disease or condition to public health authorities as required by State law.

12. Credentialing and Recredentialing

Contractor shall develop, and maintain written policies and procedures that include initial credentialing, recredentialing, recertification, and reappointment of Physicians including Primary Care Physicians and specialists in accordance with the MMCD, Credentialing and Recredentialing Policy Letter, MMCD Policy Letter 02-03. Contractor shall ensure those policies and procedures are reviewed and approved by the governing body, or designee. Contractor shall ensure that the responsibility for recommendations regarding credentialing decisions will rest with a credentialing committee or other peer review body.

A. Standards

All providers of Covered Services must be qualified in accordance with current applicable legal, professional, and technical standards and appropriately licensed, certified or registered. All providers must have

good standing in the Medicare and Medicaid/Medi-Cal programs. Providers that have been terminated from either Medicare or Medicaid/Medi-Cal cannot participate in Contractor's provider network.

B. Delegated Credentialing

Contractor may delegate credentialing and recredentialing activities. If Contractor delegates these activities, Contractor shall comply with provision 6, Delegation of Quality Improvement Activities, above.

C. Credentialing Provider Organization Certification

Contractor and their subcontractors (e.g. a medical group or independent physician organization) may obtain credentialing provider organization certification (POC) from the National Committee on Quality Assurance (NCQA). Contractor may accept evidence of NCQA POC certification in lieu of a monitoring visit at delegated physician organizations.

D. Disciplinary Actions

Contractor shall implement and maintain a system for the reporting of serious quality deficiencies that result in suspension or termination of a practitioner to the appropriate authorities. Contractor shall implement and maintain policies and procedures for disciplinary actions including, reducing, suspending, or terminating a practitioner's privileges. Contractor shall implement and maintain a provider appeal process.

E. Medi-Cal and Medicare Provider Status

The Contractor will verify that their subcontracted providers have not been terminated as Medi-Cal or Medicare providers or have not been placed on the Suspended and Ineligible Provider list. Terminated providers in either Medicare or Medi-Cal/Medicaid or on the Suspended and Ineligible Provider list, cannot participate in the Contractor's provider network.

F. Health Plan Accreditation

If Contractor has received a rating of "Excellent, "Commendable" or "Accredited" from NCQA, the Contractor shall be "deemed" to meet the DHS requirements for credentialing and will be exempt from the DHS medical review audit of Credentialing.

Deeming of credentialing certification from other private credentialing organizations will be reviewed on an individual basis.

G. Credentialing of Other Non-Physician Medical Practitioners

Contractor shall develop and maintain policies and procedures that ensure that the credentials of Nurse Practitioners, Certified Nurse Midwives, Clinical Nurse Specialists and Physician Assistants have been verified in accordance with State requirements.

13. Medical Records

A. General Requirement

Contractor shall ensure that appropriate Medical Records for Members, pursuant to Title 28, CCR, Section 1300.80(b)(4) and 42 USC § 1396a(w), shall be available to health care providers at each Encounter in accordance with Title 28 CCR, Section 1300.67.1 (c) and Title 22, CCR, Section 53861 and MMCD Policy Letter 02-02.

B. Medical Records

Contractor shall develop, implement and maintain written procedures pertaining to any form of medical records:

1) For storage and filing of medical records including: collection, processing, maintenance, storage, retrieval identification, and distribution.

2) To ensure that medical records are protected and confidential in accordance with all Federal and State law.

3) For the release of information and obtaining consent for treatment.

4) To ensure maintenance of medical records in a legible, current, detailed, organized and comprehensive manner (records may be electronic or paper copy).

C. On-Site Medical Records

Contractor shall ensure that an individual is delegated the responsibility of securing and maintaining medical records at each site.

D. Member Medical Record

Contractor shall ensure that a complete medical record is maintained for each Member in accordance with Title 22, CCR, Section 53861, that

reflects all aspects of patient care, including ancillary services, and at a minimum includes:

1) Member identification on each page; personal/biographical data in the record.
2) Member's preferred language (if other than English) prominently noted in the record, as well as the request or refusal of language/interpretation services.
3) All entries dated and author identified; for member visits, the entries shall include at a minimum, the subjective complaints, the objective findings, and the plan for diagnosis and treatment.
4) The record shall contain a problem list, a complete record of immunizations and health maintenance or preventive services rendered.
5) Allergies and adverse reactions are prominently noted in the record.
6) All informed consent documentation, including the human sterilization consent procedures required by Title 22, CCR, Sections 51305.1 through 51305.6, if applicable.
7) Reports of emergency care provided (directly by the contracted provider or through an emergency room) and the hospital discharge summaries for all hospital admissions.
8) Consultations, referrals, specialists', pathology, and laboratory reports. Any abnormal results shall have an explicit notation in the record.
9) For medical records of adults, documentation of whether the individual has been informed and has executed an advanced directive such as a Durable Power of Attorney for Health Care.
10) Health education behavioral assessment and referrals to health education services. For patients 12 years or older, a notation concerning use of cigarettes, alcohol, and substance abuse, health education, or counseling and anticipatory guidance.

UTILIZATION MANAGEMENT

1. Utilization Management (UM) Program

Contractor shall develop, implement, and continuously update and improve, a UM program that ensures appropriate processes are used to review and approve the provision of Medically Necessary Covered Services. Contractor is responsible to ensure that the UM program includes:

A. Qualified staff responsible for the UM program.

B. The separation of medical decisions from fiscal and administrative management to assure those medical decisions will not be unduly influenced by fiscal and administrative management.

C. Contractor shall ensure that the UM program allows for a second opinion from a qualified health professional at no cost to the Member.

D. Established criteria for approving, modifying, deferring, or denying requested services. Contractor shall utilize evaluation criteria and standards to approve, modify, defer, or deny services. Contractor shall document the manner in which providers are involved in the development and or adoption of specific criteria used by the Contractor.

E. An established specialty referral system to track and monitor referrals requiring prior authorization through the Contractor. The system shall include authorized, denied, deferred, or modified referrals, and the timeliness of the referrals.

Contractor shall ensure that all contracting health care practitioners are aware of the referral processes and tracking procedures.

F. The integration of UM activities into the Quality Improvement System (QIS), including a process to integrate reports on review of the number and types of appeals, denials, deferrals, and modifications to the appropriate QIS staff.

2. Pre-Authorizations and Review Procedures

Contractor shall ensure that its pre-authorization, concurrent review and retrospective review procedures meet the following minimum requirements:

A. Qualified health care professionals supervise review decisions and a qualified Physician will review all denials.

B. There is a set of written criteria or guidelines for Utilization Review that is based on sound medical evidence, is consistently applied, regularly reviewed, and updated.

C. Reasons for decisions are clearly documented.

D. Notification to Members regarding denied, deferred or modified referrals is made as specified in Exhibit A, Attachment 13, Member Services. There shall be a well-publicized appeals procedure for both providers and patients.

E. Decisions and appeals are made in a timely manner and are not unduly delayed for medical conditions requiring time sensitive services.

F. Prior Authorization requirements shall not be applied to Emergency Services, family planning services, preventive services, basic prenatal care, sexually transmitted disease services, and HIV testing.

G. Records, including any Notice of Action, shall meet the retention requirements described in Exhibit E, Attachment 2, provision 19.

H. Contractor must notify the requesting provider of any decision to deny, approve, modify, or delay a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice to the provider may be orally or in writing.

3. Timeframes for Medical Authorization

A. Emergency Care: No prior authorization required, following the reasonable person standard to determine that the presenting complaint might be an emergency.

B. Post-stabilization: Response to request within 30 minutes or the service is deemed approved in accordance with Title 22, CCR, Section 53855 (a), or any future amendments thereto.

C. Non-urgent care following an exam in the emergency room: Response to request within 30 minutes or deemed approved.

D. Concurrent Review of authorization for treatment regimen already in place: 72 hours or consistent with urgency of the Member's medical condition in accordance with Health & Safety Code Section 1367.01, or any future amendments thereto.

E. Retrospective review: Within 30 days in accordance with Health & Safety Code Section 1367.01, or any future amendments thereto.

F. Pharmaceuticals: 24 hours on all drugs that require prior authorization in accordance with Welfare & Institutions Code, Section 14185 or any future amendments thereto.

G. Routine authorizations: Five (5) business days from receipt of the information reasonably necessary to render a decision (these are requests for specialty service, cost control purposes, out-of-network not otherwise exempt from prior authorization) in accordance with Health & Safety Code, Section 1367.01, or any future amendments thereto, but, no longer than 14 days from the receipt of the request. The decision may be deferred and the time limit extended an additional 14 calendar days only where the Member or the Member's provider requests an extension, or the Contractor can provide justification upon request by the State for the need for additional information and how it is in the Member's interest. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.

H. Expedited authorizations: Three (3) working days after receipt of the request for service (these are requests in which a provider indicates, or the Contractor determines, that following the standard timeframe could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function). The time limit may be extended by up to 14 calendar days if the Member requests an extension, or if the Contractor can provide justification upon request by the State for the need for additional information and how it is in the Member's interest. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.

I. Hospice care: 24-hour response.

4. Review of Utilization Data

Contractor shall include within the UM program mechanisms to detect both under- and over-utilization of health care services. Contractor's internal reporting mechanisms used to detect Member utilization patterns shall be reported to DHS upon request.

5. Delegating UM Activities

Contractor may delegate UM activities. If Contractor delegates these activities, Contractor shall comply with Exhibit A, Attachment 4, provision 6, Delegation of Quality Improvement Activities.

PROVIDER NETWORK

1. Network Capacity

Contractor shall maintain a provider network adequate to serve sixty percent (60%) of all Eligible Beneficiaries in the proposed county and provide the full scope of benefits. Contractor will increase the capacity of the network as necessary to accommodate enrollment growth beyond the sixty percent (60%). However, after the first twelve months of operation, if Enrollments do not achieve seventy-five (75%) of the required network capacity, the Contractor's total network capacity requirement may be renegotiated.

2. Network Composition

Contractor shall maintain an adequate number of inpatient Facilities, Service Sites, professional, allied, specialist and supportive paramedical personnel within their network to provide Covered Services to its Members.

3. Provider to Member Ratios

A. Contractor shall ensure that networks continuously satisfy the following full-time equivalent provider to Member ratios:

1) Primary Care Physicians 1:2,000

2) Total Physicians 1:1,200

B. If Non-Physician Medical Practitioners are included in Contractor's provider network, each individual Non-Physician Medical Practitioner shall not exceed a full-time equivalent provider/patient caseload of one provider per 1,000 patients.

4. Physician Supervisor to Non-Physician Medical Practitioner Ratios

Contractor shall ensure compliance with Title 22, CCR, Section 51241, and that full-time equivalent Physician Supervisor to Non-Physician Medical Practitioner ratios do not exceed the following:

A. Nurse Practitioners 1:4

B. Physician Assistants 1:2

C. Four (4) Non-Physician Medical Practitioners in any combination that does not include more than three nurse midwives or two Physician assistants.

5. Emergency Services

Contractor shall have as a minimum a designated emergency service facility, providing care on a 24-hour-a-day, 7-day-a-week basis. This designated emergency service facility will have one or more Physicians and one Nurse on duty in the facility at all times.

6. Specialists

Contractor shall maintain adequate numbers and types of specialists within their network to accommodate the need for specialty care in accordance with Title 22, CCR, Section 53853(a).

7. Federally Qualified Health Center (FQHC) Services

Contractor shall meet federal requirements for access to FQHC services, including those in 42 United States Code Section 1396 b(m). Contractor shall reimburse FQHCs in accordance with Exhibit A, Attachment 8, Provider Compensation Arrangements, provision 7. If FQHC services are not available in the provider network of either the Local Initiative (LI) Health Plan in the county or Contractor, Contractor shall reimburse FQHCs for services provided out-of-plan to Contractor's Members at the FQHC rate determined by DHS. If FQHC services are not available in Contractor's provider network, but are available within DHS' time and distance standards for access to Primary Care for Contractor's Members in the LI Health Plan's provider network in the county, Contractor shall not be obligated to reimburse FQHCs for services provided out-of-plan to Members (unless authorized by Contractor).

8. Time and Distance Standard

Contractor shall maintain a network of Primary Care Physicians which are located within thirty (30) minutes or ten (10) miles of a Member's residence unless the Contractor has a DHS approved alternative time and distance standard.

9. Plan Physician Availability

Contractor shall have a plan Physician available 24 hours per day, seven days per week to coordinate the transfer of care of a Member whose emergency condition is stabilized, to authorize medically necessary post-stabilization services, and for general communication with emergency room personnel.

10. Provider Network Report

Contractor shall submit to DHS on a quarterly basis, in a format specified by DHS, a report summarizing changes in the provider network.

A. The report shall identify provider deletions and additions and the resulting impact to:

1) Geographic access for the Members;

2) Cultural and linguistic services including provider and provider staff language capability;

3) The percentage of Traditional and Safety-Net providers;

4) The number of Members assigned to each Primary Care Physician;

5) The percentage of Members assigned to Traditional and Safety-Net providers; and

6) The network providers who are not accepting new patients.

B. Contractor shall submit the report thirty (30) days following the end of the reporting quarter.

11. This item intentionally left blank.

12. Ethnic and Cultural Composition

Contractor shall ensure that the composition of Contractor's provider network meets the ethnic, cultural, and linguistic needs of Contractor's Members on a continuous basis.

13. Subcontracts

Contractor may enter into Subcontracts with other entities in order to fulfill the obligations of the Contract. In doing so, Contractor shall meet the subcontracting requirements as stated in Title 22, CCR, Section 53867 and this Contract.

A. Laws and Regulations

All Subcontracts shall be in writing and in accordance with the requirements of the Knox-Keene Health Care Services Plan Act of 1975, Health and Safety Code Section 1340 et seq.; Title 28, CCR, Section 1300

et seq.; W&I Code Section 14200 et seq.; Title 22, CCR, Section 53800 et seq.; and applicable federal and State laws and regulations.

B. Subcontract Requirements

Each Subcontract shall contain:

1) Specification of the services to be provided by the subcontractor.

2) Specification that the Subcontract shall be governed by and construed in accordance with all laws and applicable regulations governing this Contract.

3) Specification that the Subcontract or Subcontract amendments shall become effective only as set forth in subparagraph C. Departmental Approval – Non-Federally Qualified HMOs, or subparagraph D, Departmental Approval – Federally Qualified HMOs.

4) Specification of the term of the Subcontract, including the beginning and ending dates as well as methods of extension, renegotiation and termination.

5) Language comparable to Exhibit A, Attachment 8, provision 13 for those subcontractors at risk for non-contracting emergency services.

6) Subcontractor's agreement to submit reports as required by Contractor.

7) Subcontractor's agreement to make all of its books and records, pertaining to the goods and services furnished under the terms of the Subcontract, available for inspection, examination or copying:

   a) By DHS, Department of Health and Human Services (DHHS), Department of Justice (DOJ), and Department of Managed Health Care (DMHC).

   b) At all reasonable times at the subcontractor's place of business or at such other mutually agreeable location in California.

   c) In a form maintained in accordance with the general standards applicable to such book or record keeping.

d) For a term of at least five years from the close of DHS' fiscal year for the last year in which the Subcontract was in effect.

e) Including all Encounter data for a period of at least five years.

8) Full disclosure of the method and amount of compensation or other consideration to be received by the subcontractor from the Contractor.

9) Subcontractor's agreement to maintain and make available to DHS, upon request, copies of all sub-subcontracts and to ensure that all sub-subcontracts are in writing and require that the Sub-subcontractor:

a) Make all applicable books and records available at all reasonable times for inspection, examination, or copying by DHS, DHHS, DOJ and DMHC.

b) Retain such books and records for a term of at least five years from the close of DHS' fiscal year for the last year in which the sub-subcontract is in effect.

10) Subcontractor's agreement to assist Contractor in the transfer of care pursuant to Exhibit E, Attachment 2, provision 15. B. Phase out Requirements, in the event of Contract termination.

11) Subcontractor's agreement to assist Contractor in the transfer of care in the event of sub-subcontract termination for any reason.

12) Subcontractor's agreement to notify DHS in the event the agreement with the Contractor is amended or terminated. Notice is considered given when properly addressed and deposited in the United States Postal Service as first-class registered mail, postage attached.

13) Subcontractor's agreement that assignment or delegation of the Subcontract will be void unless prior written approval is obtained from DHS.

14) Subcontractor's agreement to hold harmless both the State and Members in the event the Contractor cannot or will not pay for services performed by the subcontractor pursuant to the Subcontract.

15) Subcontractor's agreement to timely gather, preserve and provide to DHS, any records in the subcontractor's possession, in accordance with Exhibit E, Attachment 2, provision 25, Records Related to Recovery for Litigation.

16) Subcontractor's agreement to provide interpreter services for Members at all provider sites.

17) Subcontractor's right to submit a grievance and Contractor's formal process to resolve Provider Grievances.

18) Subcontractor's agreement to participate and cooperate in the Contractor's Quality Improvement System.

19) Subcontractor's agreement to comply with all applicable requirements of the DHS, Medi-Cal Managed Care Program.

C. Departmental Approval - Non-Federally Qualified HMOs

Except as provided in Exhibit A, Attachment 8, Provider Compensation Arrangements, provision 7 regarding Federally Qualified Health Centers and Rural Health Clinics, a provider or management Subcontract entered into by Contractor which is not a federally qualified HMO shall become effective upon approval by DHS in writing, or by operation of law where DHS has acknowledged receipt of the proposed Subcontract, and has failed to approve or disapprove the proposed Subcontract within sixty (60) days of receipt. Within five (5) State working days of receipt, DHS shall acknowledge in writing the receipt of any material sent to DHS by Contractor for approval.

Subcontract amendments shall be submitted to DHS for prior approval at least thirty (30) days before the effective date of any proposed changes governing compensation, services, or term. Proposed changes which are neither approved or disapproved by DHS, shall become effective by operation of law thirty (30) days after DHS has acknowledged receipt or upon the date specified in the Subcontract amendment, whichever is later.

D. Departmental Approval - Federally Qualified HMOs

Except as provided in Exhibit A, Attachment 8, provision 7, Provider Compensation Arrangements, regarding Federally Qualified Health Centers and Rural Health Clinics, Subcontracts entered into by Contractor which is a federally qualified HMO shall be:

1) Exempt from prior approval by DHS.

2) Submitted to DHS upon request.

E. Public Records

Subcontracts entered into by the Contractor and all information received in accordance with this subsection will be public records on file with DHS, except as specifically exempted in statute. The names of the officers and owners of the subcontractor, stockholders owning more than ten (10) percent of the stock issued by the subcontractor and major creditors holding more than five (5) percent of the debt of the subcontractor will be attached to the Subcontract at the time the Subcontract is presented to DHS.

14. Subcontracts with Federally Qualified Health Centers and Rural Health Clinics (FQHC/RHC)

Subcontracts with FQHCs shall also meet Subcontract requirements of provision 13 above and reimbursement requirements in Exhibit A, Attachment 8, provision 7. In Subcontracts with FQHCs and RHCs where a negotiated reimbursement rate is agreed to as total payment, a provision that such rate constitutes total payment shall be included in the Subcontract.

15. Traditional and Safety-Net Providers Participation

Contractor shall establish participation standards pursuant to Title 22, CCR, Section 53800(b)(2)(C)(1) to ensure participation and broad representation of Traditional and Safety-Net Providers within a Service Area. Contractor shall maintain the percentage of Traditional and Safety-Net Provider within a Service Area submitted and approved by DHS. Federally Qualified Health Centers meet the definitions of both Traditional and Safety-Net providers.

16. Nondiscrimination In Provider Contracts

Contractor shall not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of practice of his or her license or certification under applicable State law, solely on the basis of that license or certification. If the Contractor declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision. Contractor's provider selection policies must not discriminate against providers that serve high-risk populations or specialize in conditions requiring costly treatment. This section shall not be construed to require Contractor to contract with providers beyond the number necessary to meet the needs of Contractor's Members; preclude Contractor from using different reimbursement amounts for different specialties or for different

practitioners in the same specialty; or preclude Contractor from establishing measures that are designed to maintain quality of services and control costs and is consistent with Contractor's responsibilities to Members.

PROVIDER RELATIONS

1. Exclusivity

Contractor shall not, by use of an exclusivity provision, clause, agreement, or in any other manner, prohibit any subcontractor from providing services to Medi-Cal beneficiaries who are not Members of the Contractor's plan. This prohibition is not applicable to contracts entered into between Contractor and Knox-Keene licensed health care service plans.

2. Provider Grievances

Contractor shall have a formal process to accept, acknowledge, and resolve provider grievances. A provider of medical services may submit to Contractor a grievance concerning the authorization or denial of a service; denial, deferral or modification of a prior authorization request on behalf of a Member; or the processing of a payment or non-payment of a claim by the Contractor. This process shall be communicated to subcontracting and non-contracting providers.

3. This item intentionally left blank.

4. Provider Manual

Contractor shall issue a Provider Manual and updates to the providers of Medi-Cal services. The manual and updates shall serve as a source of information to health care providers regarding Medi-Cal services, policies and procedures, statutes, regulations, telephone access and special requirements.

5. Provider Training

Contractor shall ensure that all providers receive training regarding the Medi-Cal Managed Care program in order to operate in full compliance with the Contract and all applicable Federal and State statutes and regulations. Contractor shall ensure that provider training relates to Medi-Cal Managed Care services, policies, procedures and any modifications to existing services, policies or procedures. Contractor shall conduct training for all providers within ten (10) days after the Contractor places a newly contracted provider on active status. Contractor shall ensure that provider training includes information on all Member rights specified in Exhibit A, Attachment 13, Member Services, including the right to full disclosure of health care information and the right to actively participate in health care decisions. Contractor shall ensure that ongoing training is conducted when deemed necessary by either the Contractor or the State.

6. Submittal of Inpatient Days Information

Upon DHS' written request, Contractor shall report hospital inpatient days to DHS as required by W&I Code, section 14105.985(b)(2) for the time period and in the form and manner specified in DHS' request, within thirty (30) days of receipt of the request. Contractor shall submit additional reports to DHS, as requested, for the administration of the Disproportionate Share Hospital program.

7. Emergency Department Protocols

Contractor shall develop and maintain protocols for communicating and interacting with emergency departments. Protocols shall be distributed to all emergency departments in the contracted Service Area and shall include at a minimum the following:

A. Description of telephone access to triage and advice systems used by the Contractor.

B. Plan contact person responsible for coordinating services and who can be contacted 24 hours a day.

C. Written referral procedures (including after-hours instruction) that emergency department personnel can provide to Medi-Cal Members who present at the emergency department for non-emergency services.

D. Procedures for emergency departments to report system and/or protocol failures and process for ensuring corrective action.

8. Prohibited Punitive Action Against the Provider

Contractor must ensure that punitive action is not taken against the provider who either requests an expedited resolution or supports a Member's appeal.

PROVIDER COMPENSATION ARRANGEMENTS

1. Provider Compensation

Contractor may compensate providers as Contractor and provider negotiate and agree, except, capitation rates cannot be stated as a percent of Medi-Cal revenue. This provision will not be construed to prohibit subcontracts in which compensation or other consideration is determined on a capitation basis.

2. This item intentionally left blank.

3. Physician Incentive Plan Requirements

Contractor may implement and maintain a Physician Incentive Plan only if:

A. No specific payment is made directly or indirectly under the incentive plan to a Physician or Physician group as an inducement to reduce or limit Medically Necessary Covered Services provided to an individual Member; and

B. The stop-loss protection (reinsurance), beneficiary survey, and disclosure requirements of 42 CFR 417.479, 42 CFR 422.208 and 42 CFR 422.210 are met by Contractor.

4. This item intentionally left blank.

5. Claims Processing

Contractor shall pay all claims submitted by subcontracting providers in accordance with this section, unless the subcontracting provider and Contractor have agreed in writing to an alternate payment schedule.

A. Contractor shall comply with Health and Safety Code Sections 1371 through 1371.36. Contractor shall be subject to any remedies, including interest payments provided for in these sections, if it fails to meet the standards specified in these sections.

B. Contractor shall maintain procedures for prepayment and post payment claims review, including review of data related to provider, Member and Covered Services for which payment is claimed.

C. Contractor shall maintain sufficient claims processing/tracking/payment systems capability to: comply with applicable State and federal law, regulations and Contract requirements, determine the status of received

claims, and calculate the estimate for incurred and unreported claims, as specified by Title 28, CCR, Sections 1300.77.1 and 1300.77.2.

D. Contractor shall submit claims payment summary reports to DHS on a quarterly basis. Quarterly summary reports shall provide for claim payment reporting requirement data in a form and manner specified by DHS.

1) Percent of uncontested claims that are paid or denied within 30 working days of receipt.

2) Percent of uncontested claims that are paid or denied within 45 working days of receipt.

Working days are State calendar (State Appointment Calendar, Standard 101) working days.

6. Prohibited Claims

Except in specified circumstances, Contractor and any of its Affiliates and subcontractors shall not submit a claim or demand, or otherwise collect reimbursement for any services provided under this Contract to a Medi-Cal Member. Collection of claim may be made under those circumstances described in Title 22, CCR, Sections 53866, 53220, and 53222.

7. Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC), and Indian Health Service Facilities

A. FQHCs Availability and Reimbursement Requirement

If FQHC services are not available in the provider network of either the Local Initiative Health Plan in the county or Contractor, Contractor shall reimburse non-contracting FQHCs for services provided to Contractor's Members at a level and amount of payment that is not less than the Contractor makes for the same scope of services furnished by a provider that is not a FQHC or RHC. If FQHC services are not available in Contractor's provider network, but are available within DHS' time and distance standards for access to Primary Care for Contractor's Members within the Local Initiative Health Plan's provider network in the county, Contractor shall not be obligated to reimburse non-contracting FQHCs for services provided to Contractor's Members (unless authorized by Contractor).

B. Federally Qualified Health Centers/Rural Health Clinics (FQHC/RHC)

Contractor shall submit to DHS, within thirty (30) days of a request and in the form and manner specified by DHS, the services provided and the reimbursement level and amount for each of Contractor's FQHC and RHC Subcontracts. Contractor shall certify in writing to DHS within thirty (30) days of DHS' written request that, pursuant to Welfare and Institutions Code Section 14087.325(b) and (d), as amended by Chapter 894, Statutes of 1998, FQHC and RHC Subcontract terms and conditions are the same as offered to other Subcontractors providing a similar scope of service and that reimbursement is not less than the level and amount of payment that Contractor makes for the same scope of services furnished by a provider that is not a FQHC or RHC. Contractor is not required to pay FQHCs and RHCs the Medi-Cal per visit rate for that facility. At its discretion, DHS reserves the right to review and audit Contractor's FQHC and RHC reimbursement to ensure compliance with State and federal law and shall approve all FQHC and RHC Subcontracts consistent with the provisions of Welfare and Institutions Code, Section 14087.325(h).

To the extent that Indian Health Service Facilities qualify as FQHCs or RHCs, the above reimbursement requirements shall apply to subcontracts with Indian Health Service Facilities.

C. Indian Health Service Facilities

Contractor shall reimburse Indian Health Service Facilities for services provided to Members who are qualified to receive services from an Indian Health Service Facility according to one of the reimbursement options in Title 22, CCR, Section 55140(a). Contractor shall reimburse non-contracting Indian Health Service Facilities at the approved Medi-Cal per visit rate for that facility.

8. Non-Contracting Certified Nurse Midwife (CNM) and Certified Nurse Practitioner (CNP) Reimbursement

If there are no CNMs or CNPs in Contractor's provider network, Contractor shall reimburse non-contracting CNMs or CNPs for services provided to Members at no less than the applicable Medi-Cal Fee-For-Service (FFS) rates. If an appropriately licensed non-contracting facility is used, Contractor shall pay the facility fee. For hospitals, the requirements of provision 13, paragraph C. below apply. For birthing centers, the Contractor shall reimburse no less than the applicable Medi-Cal FFS rate.

9. Non-Contracting Family Planning Providers' Reimbursement

Contractor shall reimburse non-contracting family planning providers at no less than the appropriate Medi-Cal FFS rate. Contractor shall reimburse non-contracting family planning providers for services listed in Exhibit A, Attachment 9, provision 8, Access to Services with Special Arrangements, provided to Members of childbearing age to temporarily or permanently prevent or delay pregnancy.

10. Sexually Transmitted Disease (STD)

Contractor shall reimburse local health departments and non-contracting family planning providers at no less than the appropriate Medi-Cal FFS rate, for the diagnosis and treatment of a STD episode, as defined in MMCD Policy Letter No. 96-09. Contractor shall provide reimbursement only if STD treatment providers provide treatment records or documentation of the Member's refusal to release Medical Records to Contractor along with billing information.

11. HIV Testing and Counseling

Contractor shall reimburse local health departments and non-contracting family planning providers at no less than the Medi-Cal FFS rate for HIV testing and counseling. Contractor shall provide reimbursement only if local health departments and non-contracting family planning providers make all reasonable efforts, consistent with current laws and regulations, to report confidential test results to the Contractor.

12. Immunizations

Contractor shall reimburse local health departments for the administration fee for immunizations given to Members. However, Contractor is not required to reimburse the local health department for an immunization provided to a Member who was already up to date. The local health department shall provide immunization records when immunization services are billed to the Contractor. Contractor shall not be obligated to reimburse providers other than local health departments unless they enter into an agreement with the Contractor.

13. Non-Contracting Emergency Service Providers

Contractor shall provide care under emergency circumstances in accordance with the requirements of Title 22, CCR, Section 53855 including the following:

A. Contractor shall pay for Emergency Services received by a Member from non-contracting providers. Payments to non-contracting providers shall be for the treatment of the Emergency Medical Condition including Medically

Necessary services rendered to a Member until the Member's condition has stabilized sufficiently to permit discharge, or referral and transfer in accordance with instructions from Contractor. Emergency Services shall not be subject to Prior Authorization by Contractor.

B. At a minimum, Contractor must reimburse the non-contracting emergency department and, if applicable, its affiliated providers for Physician services at the lowest level of emergency department evaluation and management CPT (Physician's Current Procedural Terminology) codes, unless a higher level is clearly supported by documentation, and for the facility fee and diagnostic services such as laboratory and radiology.

C. For hospital inpatient services, reimbursement by Contractor, or by a subcontractor who is at risk for out-of-plan Emergency Services, to a non-contracting Emergency Services provider shall be the lower of the following rates applicable to the provider at the time the services were rendered by the provider:

1) For a provider not contracting with the State under the Selected Provider Contracting Program, the lower of:

   a) The Medi-Cal Fee-For-Service rate that would be received by the provider if the service were provided for a beneficiary under the Medi-Cal Fee-For-Service program: or

   b) The inpatient rate negotiated by Contractor or subcontractor with the provider.

2) For a provider contracting with the State under the Selected Provider Contracting Program, the lower of:

   a) The average California Medical Assistance Commission (CMAC) rate for the geographic region referred to as Standard Consolidated Statistical Area in which the provider is located for the last year reported, as published in the most recent CMAC Annual Report to the Legislature; or

   b) The inpatient rate negotiated by Contractor or subcontractor with the provider.

D. For all other non-contracting providers, reimbursement by Contractor, or by a subcontractor who is at risk for out-of-plan Emergency Services, for properly documented claims for services rendered by a non-contracting provider pursuant to this provision shall be made in accordance with provision 5. Claims Processing, above, and shall be the lower of the

following rates applicable at the time the services were rendered by the provider:

1) The usual charges made to the general public by the provider.

2) The maximum Fee-For-Service rates for similar services under the Medi-Cal program.

3) The rate agreed to by Contractor and the provider.

E. Disputed Emergency Services claims may be submitted to DHS, Office of Administrative Hearings and Appeals, 1029 J Street, Suite 200, Sacramento, California, 95814 for resolution under the provisions of Section 14454 (b) of the Welfare and Institutions Code and Title 22, CCR, Section 53875. Contractor agrees to abide by the findings of DHS in such cases, to promptly reimburse the non-contracting provider within thirty (30) days of the effective date of a decision that Contractor is liable for payment of a claim and to provide proof of reimbursement in such form as the DHS Director may require. Failure to reimburse the non-contracting provider and provide proof of reimbursement to DHS within thirty (30) days shall result in liability offsets in accordance with Welfare and Institutions Code Section 14454(c) and Title 22, CCR, Section 53702.

ACCESS AND AVAILABILITY

1. General Requirement

Contractor shall ensure that each Member has a Primary Care Provider who is available at the service site for sufficient time to ensure access for the assigned Member upon reasonable request by the Member or when medically required.

Contractor shall ensure Members access to Specialists for Medically Necessary Covered Services. Contractor shall ensure adequate staff within the Service Area, including Physicians, administrative and other support staff directly and/or through Subcontracts, sufficient to assure that health services will be provided in accordance with Title 22, CCR, Section 53853(a) and consistent with all specified requirements.

2. Existing Patient-Physician Relationships

Contractor shall ensure that no traditional or safety-net provider, upon entry into the Contractor's network, suffers any disruption of existing patient-physician relationships, to the maximum extent possible.

3. Access Requirements

Contractor shall establish acceptable accessibility standards in accordance with Title 28, Section 1300.67.2.1 and as specified below. DHS will review and approve standards for reasonableness. Contractor shall communicate, enforce, and monitor providers' compliance with these standards.

A. Appointments

Contractor shall implement and maintain procedures for Members to obtain appointments for routine care, Urgent Care, routine specialty referral appointments, prenatal care, children's preventive periodic health assessments, and adult initial health assessments. Contractor shall also include procedures for follow-up on missed appointments.

B. Routine Specialty Referral

Contractor shall ensure that a Member needing a routine specialty referral receives an appointment within 30 days of request.

C. First Prenatal Visit

Contractor shall ensure that the first prenatal visit for a pregnant Member will be available within two (2) weeks upon request.

D. Waiting Times

Contractor shall develop, implement, and maintain a procedure to monitor waiting times in the providers' offices, telephone calls (to answer and return), and time to obtain various types of appointments indicated in subparagraph A. Appointments, above.

E. Telephone Procedures

Contractor shall require providers to maintain a procedure for triaging Members' telephone calls, providing telephone medical advice (if it is made available) and accessing telephone interpreters.

F. Urgent Care

Contractor shall ensure that a Member needing Urgent Care will be seen within 48 hours upon request.

G. After Hours Calls

At a minimum, Contractor shall ensure that a Physician or an appropriate licensed professional under his/her supervision will be available for after-hours calls.

H. Unusual Specialty Services

Contractor shall arrange for the provision of seldom used or unusual specialty services from specialists outside the network if unavailable within Contractor's network, when determined Medically Necessary.

4. Access to Services to Which Contractor or Subcontractor Has a Moral Objection

Contractor shall arrange for the timely referral and coordination of covered services to which the Contractor or subcontractor has religious or ethical objections to perform or otherwise support. Contractor shall demonstrate ability to arrange, coordinate and ensure provision of services through referrals at no additional expense to DHS. Contractor shall identify these services in the Member Services Guide.

5. Standing Referrals

Contractor shall provide for standing referrals to specialists in accordance with Health and Safety Code, Section 1374.16.

6. Emergency Care

Contractor shall ensure that a Member with an Emergency Condition will be seen on an emergency basis and that Emergency Services will be available and accessible within the Service Area 24-hours-a-day.

A. Contractor shall cover emergency medical services without prior authorization pursuant to Title 28, CCR, Section 1300.67(g) and Title 22, CCR, Section 53216. Contractor shall coordinate access to emergency care services in accordance with the Contractor's DHS-approved Emergency Department protocol (see Exhibit A, Attachment 7, Provider Relations).

B. Contractor shall ensure adequate follow-up care for those Members who have been screened in the Emergency Room and require non-emergency care.

C. Contractor shall ensure that a plan physician is available 24 hours a day to authorize Medically Necessary post-stabilization care and coordinate the transfer of stabilized members in an emergency department, if necessary.

7. Nurse Midwife and Nurse Practitioner Services

Contractor shall meet federal requirements for access to Certified Nurse Midwife (CNM) services as defined in Title 22, CCR, Section 51345 and Certified Nurse Practitioner (CNP) services as defined in Title 22, CCR, Section 51345.1. Contractor shall inform Members that they have a right to obtain out-of-plan CNM services.

8. Access to Services with Special Arrangements

A. Family Planning

Members have the right to access family planning services through any family planning provider without Prior Authorization. Contractor shall inform its Members in writing of their right to access any qualified family planning provider without Prior Authorization in its Member Services Guide (see Exhibit A, Attachment 13).

1) Informed Consent

Contractor shall ensure that informed consent is obtained from Medi-Cal enrollees for all contraceptive methods, including sterilization, consistent with requirements of Title 22, CCR, Sections 51305.1 and 51305.3.

2) Out-Of-Network Family Planning Services

Members of childbearing age may access the following services from out of plan family planning providers to temporarily or permanently prevent or delay pregnancy:

a) Health education and counseling necessary to make informed choices and understand contraceptive methods.

b) Limited history and physical examination.

c) Laboratory tests if medically indicated as part of decision-making process for choice of contraceptive methods. Contractor shall not be required to reimburse out-of-plan providers for pap smears, if Contractor has provided pap smears to meet the U.S. Preventive Services Task Force guidelines.

d) Diagnosis and treatment of a sexually transmitted disease episode, as defined by DHS for each sexually transmitted disease, if medically indicated.

e) Screening, testing, and counseling of at risk individuals for HIV and referral for treatment.

f) Follow-up care for complications associated with contraceptive methods provided or prescribed by the family planning provider.

g) Provision of contraceptive pills, devices, and supplies.

h) Tubal ligation.

i) Vasectomies.

j) Pregnancy testing and counseling.

B. Sexually Transmitted Diseases (STDs)

Contractor shall provide access to STD services without Prior Authorization to all Members both within and outside its provider network. Members may access out-of-plan STD services through local health department (LHD) clinics, family planning clinics, or through other community STD service providers. Members may access LHD clinics and family planning clinics for diagnosis and treatment of a STD episode. For community providers other than LHD and family planning providers, out-of-plan services are limited to one office visit per disease episode for the purposes of: (1) diagnosis and treatment of vaginal discharge and urethral discharge, (2) those STDs that are amenable to immediate diagnosis and treatment, and this includes syphilis, gonorrhea, chlamydia, herpes simplex, chancroid, Trichomoniasis, human papilloma virus, non-gonococcal urethritis, lymphogranuloma venereum and granuloma inguinale and (3) evaluation and treatment of pelvic inflammatory disease. Contractor shall provide follow-up care.

C. HIV Testing and Counseling

Members may access confidential HIV counseling and testing services through the Contractor's provider network and through the out-of-network local health department and family planning providers.

D. Minor Consent Services

Contractor shall ensure the provision of Minor Consent Services for individuals under the age of eighteen (18). Minor Consent Services shall be available within the provider network and Members shall be informed of the availability of these services. Minors do not need parental consent to access these services. Minor Consent Services are services related to:

1) Sexual assault, including rape.
2) Drug or alcohol abuse for children twelve (12) years of age or older.
3) Pregnancy.
4) Family planning.
5) Sexually transmitted diseases (STDs), designated by the Director, in children twelve (12) years of age or older.
6) Outpatient mental health care for children twelve (12) years of age or older who are mature enough to participate intelligently and

where either (1) there is a danger of serious physical or mental harm to the minor or others, or (2) the children are the alleged victims of incest or child abuse.

E. Immunizations

Members may access LHD for immunizations. Contractor shall, upon request, provide updated information on the status of Members' immunizations to LHDs. The LHD shall provide immunization records when immunization services are billed to the Contractor.

9. This item intentionally left blank.

10. Access for Disabled Members

Contractor's Facilities shall comply with the requirements of Title III of the Americans with Disabilities Act of 1990, and shall ensure access for the disabled which includes, but is not limited to, ramps, elevators, restrooms, designated parking spaces, and drinking water provision.

11. Civil Rights Act of 1964

Contractor shall ensure compliance with Title 6 of the Civil Rights Act of 1964 (42 U.S.C. Section 2000d, 45 C.F.R. Part 80) that prohibits recipients of federal financial assistance from discriminating against persons based on race, color, religion, or national origin. Contractor shall ensure equal access to health care services for limited English proficient Medi-Cal Members through provision of high quality interpreter and linguistic services.

12. Cultural and Linguistic Program

Contractor shall have a Cultural and Linguistic Services Program that incorporates the requirements of Title 22, CCR, Section 53876. Contractor shall monitor, evaluate, and take effective action to address any needed improvement in the delivery of culturally and linguistically appropriate services. Contractor shall review and update their cultural and linguistic services consistent with the group needs assessment requirements stipulated below.

A. Written Description

Contractor shall implement and maintain a written description of its Cultural and Linguistic Services Program, which shall include at minimum the following:

1) An organizational commitment to deliver culturally and linguistically appropriate health care services.

2) Goals and objectives.

3) A timetable for implementation and accomplishment of the goals and objectives.

4) An organizational chart showing the key staff persons with overall responsibility for cultural and linguistic services and activities. A narrative shall explain the chart and describe the oversight and direction to the Community Advisory Committee, provisions for support staff, and reporting relationships. Qualifications of staff, including appropriate education, experience and training shall also be described.

5) Standards and Performance requirements for the delivery of culturally and linguistically appropriate health care services.

B. Linguistic Capability of Employees

Contractor shall assess, identify and track the linguistic capability of interpreters or bilingual employees and contracted staff (clinical and non-clinical).

C. Group Needs Assessment

Contractor shall conduct a group needs assessment of its Members to determine health education needs, cultural and linguistic needs of Members that speak a primary language other than English, and the particular needs of cultural groups within the Service Area. The assessment must include an assessment of both the health and the general literacy level of the population. Contractor shall prepare and submit a report of the findings of the group needs assessment that summarizes the items listed below.

1) The methodologies and findings of the group needs assessment.

2) Identify the linguistic needs of monolingual; non-English and limited English speaking groups, as well as the cultural needs of all plan Members.

3) The services proposed to address the needs identified; and, key activities, a timeline for implementation, and the individuals responsible for key areas of the implementation plan.

Contractor shall complete the group needs assessment within six (6) months after commencement of operations under this Contract and submit the report within twelve (12) months after commencement of operations under this Contract. Contractor shall conduct a new group needs assessment every five years.

D. The results of the group needs assessment shall be considered in the development of any Marketing materials prepared by the Contractor.

E. Cultural Competency Training

Contractor shall provide cultural competency, sensitivity, or diversity training for staff, providers and subcontractors at key points of contact. The training shall cover information about the identified cultural groups in the Contractor's Service Areas, such as the groups' beliefs about illness and health; methods of interacting with providers and the health care structure; traditional home remedies that may impact what the provider is trying to do to treat the patient; and, language and literacy needs.

F. Program Implementation and Evaluation

Contractor shall develop and implement policies and procedures for assessing the performance of individuals who provide linguistic services as well as for overall monitoring and evaluation of the Cultural and Linguistic Services Program.

13. Linguistic Services

A. Contractor shall comply with Title 22, CCR, Section 53853(c) and ensure that all monolingual, non-English-speaking, or limited English proficient (LEP) Medi-Cal beneficiaries receive 24-hour oral interpreter services at all key points of contact, as defined in paragraph D of this provision, either through interpreters or telephone language services.

B. Contractor shall provide, at minimum, the following linguistic services at no cost to Medi-Cal Members:

1) Oral Interpreters, signers, or bilingual providers and provider staff at all key points of contact. These services shall be provided in all languages spoken by Medi-Cal beneficiaries and not limited to those that speak the threshold concentration standards languages.

2) Fully translated written informing materials, including but not limited to the Member Services Guide, enrollee information, welcome

packets, marketing information, and form letters including notice of action letters and grievance acknowledgement and resolution letters. Contractor shall provide translated written informing materials to all monolingual or LEP Members that speak the identified threshold or concentration standard languages. The threshold or concentration languages are identified by DHS within the Contractor's service area, and by the Contractor in its group needs assessment.

3) Referrals to culturally and linguistically appropriate community service programs.

4) Telecommunications Device for the Deaf (TDD).

C. Contractor shall provide written translation services to the following population groups within its service area as determined by DHS:

1) A population group of mandatory Medi-Cal beneficiaries residing in the Service Area who indicate their primary language as other than English, and that meet a numeric threshold of 3,000.

2) A population group of mandatory Medi-Cal beneficiaries residing in the Service Area who indicate their primary language as other than English and who meet the concentration standards of 1,000 in a single ZIP code or 1,500 in two contiguous ZIP codes.

D. Key points of contact include:

1) Medical care settings: telephone, advice and urgent care transactions, and outpatient encounters with health care providers including pharmacists.

2) Non-medical care setting: Member services, orientations, and appointment scheduling.

14. Community Advisory Committee

Contractor shall form a Community Advisory Committee (CAC) pursuant to Title 22, CCR, Section 53876 (c) that will implement and maintain community partnerships with consumers, community advocates, and Traditional and Safety-Net providers. Contractor shall ensure that the CAC is included and involved in policy decisions related to educational, operational and cultural competency issues affecting groups who speak a primary language other than English.

SCOPE OF SERVICES

1. Covered Services

Contractor shall provide or arrange for all Medically Necessary Covered Services for Members. Covered Services are those services set forth in Title 22, CCR, Chapter 3, Article 4, beginning with Section 51301, and Title 17, CCR, Division 1, Chapter 4, Subchapter 13, beginning with Section 6840, unless otherwise specifically excluded under the terms of this Contract.

2. Medically Necessary Services

For purposes of this Contract, the term "medically necessary" will include all Covered Services that are reasonable and necessary to protect life, prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury. {Title 22, CCR, §51303(a)}

When determining the medical necessity of Covered Services for a Medi-Cal beneficiary under the age of 21, "medical necessity" is expanded to include the standards set forth in Title 22, CCR, Section 51340 and 51340.1.

3. Initial Health Assessment (IHA)

An IHA consists of a history and physical examination and a health education behavioral assessment that enables a provider of primary care services to comprehensively assess the Member's current acute, chronic and preventive health needs.

A. Contractor shall cover and ensure the provision of an IHA (complete history and physical examination) in conformance with Title 22, CCR, Section 53851 (b)(1) to each new Member within timelines stipulated in provision 4 and provision 5 below.

B. Contractor shall ensure that the IHA includes a health education behavioral assessment using an age appropriate DHS approved assessment tool. Contractor is responsible for assuring that arrangements are made for follow-up services that reflect the findings or risk factors discovered during the IHA and health education behavioral assessment.

C. Contractor shall ensure that Members' completed IHA and health education behavioral assessment tool are contained in the Members' medical record and available during subsequent preventive health visits.

D. Contractor shall make reasonable attempts to contact a member and schedule an IHA. All attempts shall be documented. Documented attempts that demonstrate Contractor's unsuccessful efforts to contact a member and schedule an IHA shall be considered evidence in meeting this requirement.

4. Services for Members under Twenty-One (21) Years of Age

Contractor shall cover and ensure the provision of screening, preventive and Medically Necessary diagnostic and treatment services for Members under 21 years of age including Early and Periodic Screening, Diagnosis and Treatment (EPSDT) supplemental services.

Contractor shall ensure that appropriate diagnostic and treatment services are initiated as soon as possible but no later than 60 days following either a preventive screening or other visit that identifies a need for follow-up.

A. Provision of IHAs for Members under Age 21

1) For Members under the age of 18 months, Contractor is responsible to cover and ensure the provision of an IHA within 60 days following the date of enrollment or within periodicity timelines established by the American Academy of Pediatrics (AAP) for ages two and younger whichever is less.

2) For Members 18 months of age and older upon enrollment, Contractor is responsible to ensure an IHA is performed within 120 days of enrollment.

3) Contractor shall ensure that performance of the California Child Health and Disability Prevention (CHDP) program's age appropriate assessment due for each child at the time of enrollment is accomplished at the IHA. The initial assessment must both include, or arrange for provision of, all immunizations necessary to ensure that the child is up-to-date for age and an age appropriate health education behavioral assessment.

B. Children's Preventive Services

1) Contractor shall provide preventive health visits for all Members under twenty-one (21) years of age at times specified by the most recent AAP periodicity schedule. This schedule requires more frequent visits than does the periodicity schedule of the CHDP program. Contractor shall provide, as part of the periodic preventive visit, all age specific assessments and services required

by the CHDP program and the age specific health education behavioral assessment as necessary.

2) Where the AAP periodicity exam schedule is more frequent than the CHDP periodicity examination schedule, Contractor shall ensure that the AAP scheduled assessment includes all assessment components required by the CHDP for the lower age nearest to the current age of the child.

3) Where a request is made for children's preventive services by the Member, the Member's parent(s) or guardian or through a referral from the local CHDP program, an appointment shall be made for the Member to be examined within two weeks of the request.

4) At each non-emergency Primary Care Encounter with Members under the age of twenty-one (21) years, the Member (if an emancipated minor) or the parent(s) or guardian of the Member shall be advised of the children's preventive services due and available from Contractor, if the Member has not received children's preventive services in accordance with CHDP preventive standards for children of the Members' age. Documentation shall be entered in the Member's Medical Record which shall indicate the receipt of children's preventive services in accordance with the CHDP standards or proof of voluntary refusal of these services in the form of a signed statement by the Member (if an emancipated minor) or the parent(s) or guardian of the Member. If the responsible party refuses to sign this statement, the refusal shall be noted in the Member's Medical Record.

5) The Confidential Screening/Billing Report form, PM 160-PHP, shall be used to report all children's preventive services Encounters. The Contractor shall submit completed forms to DHS and to the local children's preventive services program within thirty (30) days of the end of each month for all Encounters during that month.

C. Immunizations

Contractor shall ensure that all children are fully immunized during or immediately following (within 30 days) a health care visit. Contractor shall cover and ensure the timely provision of vaccines in accordance with the most recent childhood immunization schedule and recommendations published by the Advisory Committee on Immunization Practices (ACIP). Documentation shall be entered in the Members Medical Record which shall indicate the receipt of vaccines or proof of voluntary refusal of vaccines in the form of a signed statement by the Member (if an

emancipated minor) or the Parent(s) or guardian of the Member. If the responsible party refuses to sign this statement, the refusal shall be noted in the Member's Medical Record.

D. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Supplemental Services

For Members under the age of twenty-one (21) years, Contractor shall provide or arrange and pay for EPSDT supplemental services, including case management and supplemental nursing services, as defined in Title 22, CCR, Section 51184, except when EPSDT supplemental services are provide as CCS services pursuant to Exhibit A, Attachment 11, provision 8, regarding CCS Services, or as mental health services pursuant to provision 7 below, regarding Mental Health Services. Contractor shall determine the medical necessity of EPSDT supplemental services using the criteria established in Title 22, CCR, Sections 51340 and 51340.1.

EPSDT supplemental services include targeted case management services designed to assist children in gaining access to necessary medical, social, educational and other services.

5. Services for Adults

A. IHAs for Adults (Age 21 and older)

Contractor shall cover and ensure that an IHA for adult Members is performed within 120 days of enrollment.

Contractor shall ensure that the performance of the initial complete history and physical exam for adults includes, but is not limited to:

1) blood pressure,
2) height and weight,
3) total serum cholesterol measurement for men ages 35 and over and women ages 45 and over,
4) clinical breast examination for women over 40,
5) mammogram for women age 50 and over,
6) Pap smear (or arrangements made for performance) on all women determined to be sexually active,
7) chlamydia screen for all sexually active females aged 21 and older who are determined to be at high-risk for chlamydia infection using the most current CDC guidelines. These guidelines include the screening of all sexually active females aged 21 through 25 years of age,

8) screening for TB risk factors including a Mantoux skin test on all persons determined to be at high risk, and,

9) health education behavioral risk assessment.

B. Adult Preventive Services

Contractor shall cover and ensure the delivery of all preventive services and medically necessary diagnostic and treatment services for adult Members.

1) Contractor shall ensure that the latest edition of the Guide to Clinical Preventive Services published by the U.S. Preventive Services Task Force (USPSTF) is used to determine the provision of clinical preventive services to asymptomatic, healthy adult Members [age twenty-one (21) or older]. As a result of the IHA or other examination, discovery of the presence of risk factors or disease conditions will determine the need for further follow-up, diagnostic, and/or treatment services. In the absence of the need for immediate follow-up, the core preventive services identified in the requirements for the IHA for adults described above shall be provided in the frequency required by the USPSTF Guide to Clinical Preventive Services.

2) Contractor shall cover and ensure the provision of all medically necessary diagnostic, treatment, and follow-up services which are necessary given the findings or risk factors identified in the IHA or during visits for routine, urgent, or emergent health care situations. Contractor shall ensure that these services are initiated as soon as possible but no later than 60 days following discovery of a problem requiring follow up.

C. Immunizations

Contractor is responsible for assuring that all adults are fully immunized. Contractor shall cover and ensure the timely provision of vaccines in accordance with the most current California Adult Immunization recommendations.

In addition, Contractor shall cover and ensure the provision of age and risk appropriate immunizations in accordance with the findings of the IHA, other preventive screenings and/or the presence of risk factors identified in the health education behavioral assessment.

6. Pregnant Women

A. Prenatal Care

Contractor shall cover and ensure the provision of all Medically Necessary services for pregnant women. Contractor shall ensure that the most current standards or guidelines of the American College of Obstetricians and Gynecologists (ACOG) are utilized as the minimum measure of quality for perinatal services.

B. Risk Assessment

Contractor shall implement a comprehensive risk assessment tool for all pregnant female Members that is comparable to the American College of Obstetrics and Gynecology standard and Comprehensive Perinatal Services Program (CPSP) standards per Title 22, CCR, Section 51348. The results of this assessment shall be maintained as part of the obstetrical record and shall include medical/obstetrical, nutritional, psychosocial, and health education needs risk assessment components. The risk assessment tool shall be administered at the initial prenatal visit, once each trimester thereafter and at the postpartum visit. Risks identified shall be followed up on by appropriate interventions, which must be documented in the medical record.

C. Referral to Specialists

Contractor shall ensure that pregnant women at high risk of a poor pregnancy outcome are referred to appropriate specialists including perinatologists and have access to genetic screening with appropriate referrals. Contractor shall also ensure that appropriate hospitals are available within the provider network to provide necessary high-risk pregnancy services.

7. Services for All Members

A. Health Education

1) Contractor shall implement and maintain a health education system that includes programs, services, functions, and resources necessary to provide health education, health promotion and patient education for all Members.

2) Contractor shall ensure administrative oversight of the health education system by a qualified full-time health educator. This

individual shall possess a master's degree in public or community health with specialization in health education.

3) Contractor shall provide health education programs and services at no charge to Members directly and/or through subcontracts or other formal agreements with providers that have expertise in delivering health education services to the Member population.

4) Contractor shall ensure the organized delivery of health education programs using educational strategies and methods that are appropriate for Members and effective in achieving behavioral change for improved health.

5) Contractor shall ensure that health education materials are written at the sixth grade reading level and are culturally and linguistically appropriate for the intended audience.

6) Contractor shall maintain a health education system that provides educational interventions addressing the following health categories and topics:

   a) Appropriate use of health care services: managed health care; preventive and primary health care; obstetrical care; health education services; and, complimentary and alternative care.

   b) Risk-reduction and healthy lifestyles: tobacco use and cessation; alcohol and drug use; injury prevention; prevention of sexually transmitted diseases; HIV and unintended pregnancy; nutrition, weight control, and physical activity; and, parenting.

   c) Self-care and management of health conditions: pregnancy; asthma; diabetes; and, hypertension.

7) Contractor shall ensure that Members receive point of service education as part of preventive and primary health care visits. Contractor shall provide education, training, and program resources to assist contracting medical providers in the delivery of health education services for Members.

8) Contractor shall maintain health education policies and procedures, and standards and guidelines; conduct appropriate levels of program evaluation; and, monitor performance of providers that are

contracted to deliver health education services to ensure effectiveness.

9) Contractor shall periodically review the health education system to ensure appropriate allocation of health education resources, and maintain documentation that demonstrates effective implementation of the health education requirements.

B. Hospice Care

Contractor shall cover and ensure the provision of hospice care services. Contractor shall ensure that Members and their families are fully informed of the availability of hospice care as a covered service and the methods by which they may elect to receive these services. For individuals who have elected hospice care, Contractor shall arrange for continuity of medical care, including maintaining established patient-provider relationships, to the greatest extent possible. Contractor shall cover the cost of all hospice care provided. Contractor is also responsible for all medical care not related to the terminal condition.

Admission to a nursing facility of a Member who has elected hospice services as described in Title 22, CCR, Section 51349, does not affect the Member's eligibility for enrollment under this Contract. Hospice services are covered services under this Contract and are not long term care services regardless of the Member's expected or actual length of stay in a nursing facility.

Members with a terminal condition covered by CCS must be clearly informed that election of hospice will terminate the child's eligibility for CCS services.

C. Vision Care - Lenses

Contractor shall cover and ensure the provision of eye examinations and prescriptions for corrective lenses as appropriate for all Members. Contractor shall arrange for the fabrication of optical lenses for Members through Prison Industry Authority (PIA) optical laboratories. Contractor shall cover the cost of the eye examination and dispensing of the lenses for Members. DHS will reimburse PIA for the fabrication of the optical lenses in accordance with the contract between DHS and PIA.

D. Mental Health Services

1) Contractor shall cover outpatient mental health services that are within the scope of practice of Primary Care Physicians.

Contractor's policies and procedures shall define and describe what services are to be provided by Primary Care Physicians. In addition, Contractor shall cover and ensure the provision of psychotherapeutic drugs prescribed by its Primary Care Providers, except those specifically excluded in this Contract as stipulated below.

2) Contractor shall cover and pay for all Medically Necessary Covered Services for the Member, including the following services:

   a) Emergency room professional services as described in Title 22, CCR, Section 53855, except services provided by psychiatrists, psychologists, licensed clinical social workers, marriage, family and child counselors, or other Specialty Mental Health Providers.

   b) Facility charges for emergency room visits which do not result in a psychiatric admission.

   c) All laboratory and radiology services when these services are necessary for the diagnosis, monitoring, or treatment of a Member's mental health condition.

   d) Emergency medical transportation services necessary to provide access to all Medi-Cal Covered Services, including emergency mental health services, as described in Title 22, CCR, Section 51323.

   e) All non-emergency medical transportation services, as provided for in Title 22, CCR, Section 51323, required by Members to access Medi-Cal covered mental health services, subject to a written prescription by a Medi-Cal Specialty Mental Health Provider, except when the transportation is required to transfer the Member from one facility to another, for the purpose of reducing the local Medi-Cal mental health program's cost of providing services.

   f) Medically Necessary Covered Services after Contractor has been notified by a specialty mental health provider that a Member has been admitted to a psychiatric inpatient hospital, including the initial health history and physical examination required upon admission and any consultations related to Medically Necessary Covered Services. However, notwithstanding this requirement, Contractor shall not be

responsible for room and board charges for psychiatric inpatient hospital stays by Members.

g) All Medically Necessary Medi-Cal covered psychotherapeutic drugs for Members not otherwise excluded under this Contract.

i. This includes reimbursement for covered psychotherapeutic drugs prescribed by out-of-plan psychiatrists for Members.

ii. Contractor may require that covered prescriptions written by out-of-plan psychiatrists be filled by pharmacies in Contractor's provider network.

iii. Reimbursement to pharmacies for those psychotherapeutic drugs listed in Attachment 10-A (consisting of one page), and psychotherapeutic drugs classified as Anti-Psychotics and approved by the FDA after July 1,1997, shall be reimbursed through the Medi-Cal fee-for-service program, whether these drugs are provided by a pharmacy contracting with Contractor or by an out-of-plan pharmacy provider. To qualify for reimbursement under this provision, a pharmacy must be enrolled as a Medi-Cal provider in the Medi-Cal fee-for-service program.

h) Paragraphs c), e), and f) above shall not be construed to preclude Contractor from: 1) requiring that Covered Services be provided through Contractor's provider network, to the extent possible, or 2) applying Utilization Review controls for these services, including Prior Authorization, consistent with Contractor's obligation to provide Covered Services under this Contract.

3) Contractor shall develop and implement a written internal policy and procedure to ensure that Members who need specialty mental health services (services outside the scope of practice of Primary Care Physicians) are referred to and are provided mental health services by an appropriate Medi-Cal Fee-For-Service (FFS) mental health provider or to the local mental health plan for specialty mental health services in accordance with Exhibit A, Attachment 11, provision 5.

4) Contractor shall establish and maintain mechanisms to identify Members who require non-covered psychiatric services and ensure appropriate referrals are made. Contractor shall continue to cover and ensure the provision of primary care and other services unrelated to the mental health treatment and coordinate services between the Primary Care Provider and the psychiatric service provider(s). Contractor shall enter into a Memorandum of Understanding with the county mental health plan in accordance with Exhibit A, Attachment 12, provision 3, Local Health Department Coordination regarding Local Mental Health Plan Coordination.

E. Tuberculosis (TB)

TB screening, diagnosis, treatment and follow-up are covered under the Contract. Contractor shall provide TB care and treatment in compliance with the guidelines recommended by American Thoracic Society and the Centers for Disease Control and Prevention.

Contractor shall coordinate with Local Health Departments in the provision of Direct Observed Therapy as required in Exhibit A, Attachment 11, provision 15, regarding Coordination of Care, Direct Observed Therapy for Treatment of Tuberculosis and Exhibit 12, Local Health Department Coordination.

F. Pharmaceutical Services and Provision of Prescribed Drugs

1) Contractor shall cover and ensure the provision of all prescribed drugs and Medically Necessary pharmaceutical services. Contractor shall provide pharmaceutical services and prescription drugs in accordance with all Federal and State laws and regulations including, but not limited to the California State Board of Pharmacy Laws and Regulations, Title 22, CCR, Sections 53214 and 53854 and Title 16, Sections 1707.1, 1707.2, and 1707.3. Prior authorization requirements for pharmacy services and provision of prescribed drugs must be clearly described in the Member Services Guide and provider manuals of the Contractor.

At a minimum, Contractor shall arrange for pharmaceutical services to be available during regular business hours, and shall ensure the provision of drugs prescribed in emergency circumstances in amounts sufficient to last until the Member can reasonably be expected to have the prescription filled.

Contractor shall develop and implement effective drug utilization reviews and treatment outcomes systems to optimize the quality of pharmacy services.

2) Contractor shall submit to DHS a complete formulary prior to the beginning of operations. Thereafter, a report of changes to the formulary shall be submitted to DHS upon request and on an annual basis. Contractor's formulary shall be comparable to the Medi-Cal FFS list of contract drugs, except for drugs carved out through specific contract agreements. Comparable means that the Contractor's formulary must contain drugs which represent each mechanism of action sub-class within all major therapeutic categories of prescription drugs included in the Medi-Cal FFS list of contract drugs. All drugs listed on the Medi-Cal FFS list need not be included in Contractor's formulary.

3) The Contractor shall implement and maintain a process to ensure that its formulary is reviewed and updated no less than quarterly. This review and update must consider all drugs approved by the FDA and/or added to Medi-Cal Managed Care's list of contract drugs. Deletions to the formulary must be documented and justified.

4) Contractor's process should also ensure that drug utilization reviews are appropriately conducted and that pharmacy service and drug utilization encounter data are provided to DHS on a monthly basis.

5) Reimbursement to pharmacies for those drugs for the treatment of HIV/AIDS listed in Exhibit A, Attachment 10-B (consisting of one page) classified as Nucleoside Analogues or Nucleoside Reverse Transcriptase Inhibitors, Non-Nucleoside Reverse Transcriptase Inhibitors and Protease Inhibitors approved by the FDA after July 1, 1997, shall be reimbursed through the Medi-Cal FFS program, whether these drugs are provided by a pharmacy contracting with Contractor or by an out-of-plan pharmacy provider. To qualify for reimbursement under this provision, a pharmacy must be enrolled as a Medi-Cal provider in the Medi-Cal FFS program.

EXCLUDED PSYCHOTHERAPEUTIC DRUGS

Generic Name

Amantadine HCL
Benztropine Mesylate
Biperiden HCL
Biperiden Lactate
Chlorpromazine HCL
Chlorprothixene
Clozapine
Fluphanazine Decanoate
Fluphanazine Enanthate
Fluphanazine HCL
Haloperidol
Haloperidol Deconoate
Haloperidol Lactate
Isocarboxazid
Lithium Carbonate
Lithium Citrate
Loxapine HCL
Loxapine Succinate
Mesoridazine Besylate
Molindone HCL
Olanzapine
Perphenazine
Phenelzine Sulfate
Pimozide
Procyclidine HCL
Promazine HCL
Quetiapine
Risperidone
Thioridazine HCL
Thiothixene
Thiothixene HCL
Tranylcypromine Sulfate
Trifluoperazine HCL
Triflupromazine HCL
Trihexphenidyl HCL
Ziprasidone Mesylate

EXCLUDED DRUGS FOR THE TREATMENT OF HUMAN IMMUNODEFICIENCY VIRUS (HIV) AND ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS)

Generic Name

Abacavir Sulfate
Abacavir Sulfate/Lamivudine/Zidovudine
Amprenavir
Atazanavir Sulfate
Emtricitabine
Enfuvirtide
Indinavir Sulfate
Efavirenz
Lamivudine
Saquinavir
Lopinavir/Ritonavir
Ritonavir
Delavirdine Mesylate
Saquinavir Mesylate
Tenofovir Disoproxil Fumarate
Nelfinavir Mesylate
Nevirapine
Stavudine
Zidovudine/Lamivudine

CASE MANAGEMENT AND COORDINATION OF CARE

1. Comprehensive Case Management and Coordination of Care Services

Contractor shall provide basic Comprehensive Medical Case Management to each Member.

Contractor shall maintain procedures for monitoring the coordination of care provided to Members, including but not limited to all Medically Necessary services delivered both within and outside the Contractor's provider network.

2. Targeted Case Management Services

Contractor is responsible for determining whether a member requires Targeted Case Management (TCM) services, and must refer members who are eligible for TCM services to a Regional Center or local governmental health program as appropriate for the provision of TCM services.

If a Member is receiving TCM services as defined in Title 22, CCR, Section 51185(h) and as specified in Title 22, CCR, Section 51351, Contractor shall be responsible for coordinating the Member's health care with the TCM provider and for determining the medical necessity of diagnostic and treatment services recommended by the TCM provider that are Covered Services under the Contract.

If Members under age twenty-one (21) are not accepted for TCM services, see Exhibit A, Attachment 10, provision 4, Contractor shall ensure the Members' access to services comparable to EPSDT TCM services.

3. Disease Management Program

Contractor is responsible for initiating and maintaining a disease management program. Contractor shall determine the program's targeted disease conditions and implement a system to identify and encourage Members to participate.

4. Out-of-Plan Case Management and Coordination of Care

Contractor shall implement procedures to identify individuals who may need or who are receiving services from out of plan providers and/or programs in order to ensure coordinated service delivery and efficient and effective joint case management for services presented in provisions 5 through 16 below.

5. Specialty Mental Health

A. Specialty Mental Health Services

1) All Specialty Mental Health Services (inpatient and outpatient) are excluded from this Contract.

2) Contractor shall make appropriate referrals for Members needing Specialty Mental Health Services as follows:

a) For those Members with a tentative psychiatric diagnosis which meets eligibility criteria for referral to the local Medi-Cal mental health plan, as defined in MMCD Mental Health Policy Letter 00-01 Revised, the Member shall be referred to the local mental health plan.

b) For those Members whose psychiatric diagnosis is not covered by the local Medi-Cal mental health plan, the Member shall be referred to an appropriate fee-for-service Medi-Cal mental health provider. Contractor shall consult with the local Medi-Cal mental health plan as necessary to identify other appropriate community resources and to assist the Member to locate available mental health services.

3) Disputes between Contractor and the local Medi-Cal mental health plan regarding this section shall be resolved pursuant to Title 9, CCR, Section 1850.505. Any decision rendered by DHS and the California Department of Mental Health regarding a dispute between Contractor and the local Medi-Cal mental health plan concerning provision of mental health services or Covered Services required under this Contract shall not be subject to the dispute procedures specified in Exhibit E, Attachment 2, provision 18 regarding Disputes.

B. Local Mental Health Plan Coordination

Contractor shall execute a Memorandum of Understanding (MOU) with the local mental health plan (MHP) as stipulated in Exhibit A, Attachment 12 Local Health Department Coordination, provision 3, for the coordination of Specialty Mental Health Services to Members.

6. Alcohol and Substance Abuse Treatment Services

Alcohol and substance abuse treatment services available under the Drug Medi-Cal program as defined in Title 22, CCR, Section 51341.1, and outpatient heroin

detoxification services defined in Title 22, CCR, Section 51328 are excluded from this Contract.

Contractor shall identify individuals requiring alcohol and or substance abuse treatment services and arrange for their referral to the Alcohol and Other Drugs Program, including outpatient heroin detoxification providers, for appropriate services. Contractor shall assist Members in locating available treatment service sites. To the extent that treatment slots are not available in the Alcohol and other Drugs Program within the Contractor's Service Area, the Contractor shall pursue placement outside the area. Contractor shall continue to cover and ensure the provision of primary care and other services unrelated to the alcohol and substance abuse treatment and coordinate services between the primary care providers and the treatment programs.

7. Services for Children with Special Health Care Needs

Children with Special Health Care Needs (CSHCN) are defined as "those who have or are at increased risk for a chronic physical, behavioral, developmental, or emotional conditions and who also require health or related services of a type or amount beyond that required by children generally".

Contractor shall implement and maintain a program for CSHCN which includes, but is not limited to, the following:

A. Standardized procedures for the identification of CSHCN, at enrollment and on a periodic basis thereafter;

B. Methods for ensuring and monitoring timely access to pediatric specialists, sub-specialists, ancillary therapists, and specialized equipment and supplies; these may include assignment to a specialist as PCP, standing referrals, or other methods as defined by contractor;

C. Methods for ensuring that each CSHCN receives a comprehensive assessment of health and related needs, and development of a written treatment plan based on that assessment;

D. A program for case management or care coordination for CSHCN, including coordination with other agencies which provide services for children with special health care needs (e.g. mental health, substance abuse, Regional Center, CCS, local education agency, child welfare agency); and,

E. Methods for monitoring and improving the quality and appropriateness of care for children with special health care needs.

8. California Children Services (CCS)

Services provided by the CCS program are not covered under this contract. Upon adequate diagnostic evidence that a Medi-Cal Member under 21 years of age may have a CCS eligible condition, Contractor shall refer the Member to the local CCS office for determination of eligibility.

A. Contractor shall develop and implement written policies and procedures for identifying and referring children with CCS-eligible conditions to the local CCS program. The policies and procedures shall include, but not be limited to those which:

1) Ensure that Contractor's providers perform appropriate baseline health assessments and diagnostic evaluations which provide sufficient clinical detail to establish, or raise a reasonable suspicion, that a Member has a CCS-eligible medical condition;

2) Assure that Contracting Providers understand that CCS reimburses only CCS-paneled providers and CCS-approved hospitals within Contractor's network; and only from the date of referral;

3) Enable initial referrals of Member's with CCS-eligible conditions to be made to the local CCS program by telephone, same-day mail or FAX, if available. The initial referral shall be followed by submission of supporting medical documentation sufficient to allow for eligibility determination by the local CCS program.

4) Ensure that Contractor continues to provide all Medically Necessary Covered Services to the Member until CCS eligibility is confirmed.

5) Ensure that, once eligibility for the CCS program is established for a Member, Contractor shall continue to provide all Medically Necessary Covered Services that are not authorized by CCS and shall ensure the coordination of services and joint case management between its Primary Care Providers, the CCS specialty providers, and the local CCS program.

6) If the local CCS program does not approve eligibility, Contractor remains responsible for the provision of all Medically Necessary Covered Services to the Member. If the local CCS program denies authorization for any service, Contractor remains responsible for obtaining the service, if it is Medically Necessary, and paying for the service if it has been provided.

B. Contractor shall execute a Memorandum of Understanding (MOU) with the local CCS program as stipulated in Exhibit A, Attachment 12, provision 2, Local Health Department Coordination for the coordination of CCS services to Members.

C. The CCS program authorizes Medi-Cal payments to Contractor network physicians who currently are members of the CCS panel and to other providers who provided CCS-covered services to the Member during the CCS-eligibility determination period who are determined to meet the CCS standards for paneling in accordance with subparagraph D. below. Contractor shall inform providers, except as noted above, that CCS reimburses only CCS paneled providers. The Contractor shall submit information to the CCS program on all providers who have provided services to a Member thought to have a CCS eligible condition.

Authorization for payment shall be retroactive to the date the CCS program was informed about the Member through an initial referral by Contractor or a Contractor network physician, via telephone, FAX, or mail. In an emergency admission, Contractor or Contractor network physician shall be allowed until the next business day to inform the CCS program about the Member. Authorization shall be issued upon confirmation of panel status or completion of the process described above.

9. Services for Persons with Developmental Disabilities

A. Contractor shall develop and implement procedures for the identification of Members with developmental disabilities.

B. Contractor shall refer Members with developmental disabilities to a Regional Center for the developmentally disabled for evaluation and for access to those non-medical services provided through the Regional Centers such as but not limited to, respite, out-of-home placement, and supportive living. Contractor shall participate with Regional Center staff in the development of the individual developmental services plan required for all persons with developmental disabilities, which includes identification of all appropriate services, including medical care services, which need to be provided to the Member.

C. Services provided under the Home and Community-Based Services (HCBS) waiver programs to persons with developmental disabilities are not covered under this Contract. Contractor shall implement and maintain systems to identify Members with developmental disabilities that may meet the requirements for participation in this waiver and refer these Members to the HCBS Waiver program administered by the State Department of Developmental Services (DDS).

If DDS concurs with the Contractor's assessment of the Member and there is available placement in the waiver program, the Member will receive waiver services while enrolled in the plan. Contractor shall continue to provide all Medically Necessary Covered Services.

D. Contractor shall execute a Memorandum of Understanding (MOU) with the local Regional Centers as stipulated in Exhibit A, Attachment 12, provision 2, Local Health Department Coordination for the coordination of services for Members with developmental disabilities.

10. Early Intervention Services

Contractor shall develop and implement systems to identify children who may be eligible to receive services from the Early Start program and refer them to the local Early Start program. These children would include those with a condition known to lead to developmental delay, those in whom a significant developmental delay is suspected, or whose early health history places them at risk for delay. Contractor shall collaborate with the local Regional Center or local Early Start program in determining the Medically Necessary diagnostic and preventive services and treatment plans for Members participating in the Early Start program. Contractor shall provide case management and care coordination to the Member to ensure the provision of all Medically Necessary covered diagnostic, preventive and treatment services identified in the individual family service plan developed by the Early Start program, with Primary Care Provider participation.

11. Local Education Agency Services

Local Education Agency (LEA) assessment services are services specified in Title 22, CCR Section 51360(b) and provided to students who qualify based on Title 22, CCR, Section 51190.1. LEA services provided pursuant to an Individual Education Plan as set forth in Education Code, Section 56340 et seq. or Individual Family Service Plan as set forth in Government Code, Section 95020, are not covered under this Contract.

12. School Linked CHDP Services

A. Coordination of Care

Contractor shall maintain a "medical home" and ensure the overall coordination of care and case management of Members who obtain CHDP services through the local school districts or school sites.

B. Cooperative Arrangements

Contractor shall enter into one or a combination of the following arrangements with the local school district or school sites:

1) Cooperative arrangements (e.g. Subcontracts) with school districts or school sites to directly reimburse schools for the provision of some or all of the CHDP services, including guidelines for sharing of critical medical information. The arrangements shall also include guidelines specifying coordination of services, reporting requirements, quality standards, processes to ensure services are not duplicated, and processes for notification to Member/student/parent on where to receive initial and follow-up services.

2) Cooperative arrangements whereby the Contractor agrees to provide or contribute staff or resources to support the provision of school linked CHDP services.

3) Referral protocols/guidelines between the Contractor and the school sites, which merely screen, for the need of CHDP services receive those services from the Contractor within the required State and federal time frames. This shall include strategies for the Contractor to follow-up and document that services are provided to the Member.

4) Any innovative approach that the Contractor may develop to assure access to CHDP services and coordination with and support for school based health care services.

C. Subcontracts

Contractor shall ensure that the Subcontracts with the local school districts or school sites meet the requirements of Exhibit A, Attachment 6, provision 13, regarding Subcontracts, and address the following: the population covered, beginning and end dates of the agreement, services covered, practitioners covered, outreach, information dissemination, educational responsibilities, utilization review requirements, referral procedures, medical information flows, patient information confidentiality, quality assurance interface, data reporting requirements, and grievance/complaint procedures.

13. Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) Home and Community Based Services Waiver Program

Services provided under the HIV/AIDS Home and Community Based Services Waiver are not covered under this Contract. Contractor shall maintain procedures for identifying Members who may be eligible for the HIV/AIDS Home and Community Based Services Waiver Program and shall facilitate referrals of these Members to the HIV/AIDS Home and Community Based Services Waiver Program.

Medi-Cal beneficiaries enrolled in Medi-Cal managed care health plans who are subsequently diagnosed with HIV/AIDS, according to the definition most recently published in the Mortality and Morbidity Report from the Centers for Disease Control and Prevention, may participate in the HIV/AIDS Home and Community Based Services Waiver Program without having to disenroll from their Medi-Cal managed care plan. Members of Medi-Cal managed care plans must meet the eligibility requirements of the HIV/AIDS Home and Community Based Services Medi-Cal Waiver Program and enrollment is dependent on available space. Persons already enrolled in the HIV/AIDS Home and Community Based Services Medi-Cal Waiver Program may voluntarily enroll in a Medi-Cal managed care health plan.

14. Dental

Dental services are not covered under this Contract. Contractor shall cover and ensure that dental screenings for all Members are included as a part of the initial health assessment. For Members under twenty-one (21) years of age, a dental screening/oral health assessment shall be performed as part of every periodic assessment, with annual dental referrals made commencing at age 3 or earlier if conditions warrant. Contractor shall ensure that Members are referred to appropriate Medi-Cal dental providers.

Contractor shall cover and ensure the provision of covered medical services related to dental services that are not provided by dentists or dental anesthetists. Covered medical services include: contractually covered prescription drugs; laboratory services; and, pre-admission physical examinations required for admission to an out-patient surgical service center or an in-patient hospitalization required for a dental procedure (including facility fees and anesthesia services for both inpatient and outpatient services). Contractor may require Prior Authorization for medical services required in support of dental procedures.

If the Contractor requires pre-authorization for these services, Contractor shall develop and publish the procedures for obtaining pre-authorization to ensure that services for the Member are not unduly delayed. Contractor shall submit such procedures to DHS for review and approval.

15. Direct Observed Therapy (DOT) for Treatment of Tuberculosis (TB)

A. DOT is offered by local health departments (LHDs) and is not covered under this Contract. Contractor shall assess the risk of noncompliance with drug therapy for each Member who requires placement on anti-tuberculosis drug therapy.

The following groups of individuals are at risk for non-compliance for the treatment of TB: Members with demonstrated multiple drug resistance (defined as resistance to Isoniazid and Rifampin); Members whose treatment has failed or who have relapsed after completing a prior regimen; children and adolescents; and, individuals who have demonstrated noncompliance (those who failed to keep office appointments). Contractor shall refer Members with active TB and who have any of these risks to the TB Control Officer of the LHD for DOT.

Contractor shall assess the following groups of Members for potential noncompliance and for consideration for DOT: substance abusers, persons with mental illness, the elderly, persons with unmet housing needs, and persons with language and/or cultural barriers. If, in the opinion of the Contractor's providers, a Member with one or more of these risk factors is at risk for noncompliance, the Member shall be referred to the LHD for DOT.

Contractor shall provide all Medically Necessary Covered Services to the Member with TB on DOT and shall ensure joint case management and coordination of care with the LHD TB Control Officer.

B. Contractor shall execute a Memorandum of Understanding (MOU) with the LHD as stipulated in Exhibit A, Attachment 12, provision 2, Local Health Department Coordination for the provision of DOT.

16. Women, Infants, and Children (WIC) Supplemental Nutrition Program

A. WIC services are not covered under this Contract. However, Contractor shall have procedures to identify and refer eligible Members for WIC services. As part of the referral process, Contractor shall provide the WIC program with a current hemoglobin or hematocrit laboratory value. Contractor shall also document the laboratory values and the referral in the Member's medical record.

Contractor, as part of its initial health assessment of Members, or, as part of the initial evaluation of newly pregnant women, shall refer and document the referral of pregnant, breastfeeding, or postpartum women or

a parent/guardian of a child under the age of five to the WIC program as mandated by Title 42, CFR 431.635(c).

B. Contractor shall execute a Memorandum of Understanding (MOU) with the WIC program as stipulated in Exhibit A, Attachment 12, provision 2, Local Health Department Coordination for services provided to Members through the WIC program.

17. Excluded Services Requiring Member Disenrollment

Contractor shall continue to cover and ensure that all Medically Necessary services are provided to Members who must disenroll and receive the following services through the Medi-Cal Fee-for-Service program until the date of disenrollment is effective.

A. Long Term Care (LTC)

Long-term care (LTC) is defined as care in a facility for longer than the month of admission plus one month. LTC services are not covered under this Contract. Contractor shall cover Medically Necessary nursing care provided from the time of admission and up to one month after the month of admission.

Contractor shall ensure that Members, other than Members requesting hospice services, in need of nursing Facility services are placed in a health care facility that provides the level of care most appropriate to the Member's medical needs. These health care facilities include Skilled Nursing Facilities, subacute facilities, pediatric subacute facilities, and Intermediate Care Facilities. Contractor shall base decisions on the appropriate level of care on the definitions set forth in Title 22, CCR, Sections 51118, 51120, 51120.5, 51121, 51124.5, and 51124.6 and the criteria for admission set forth in Title 22, CCR, Sections 51335, 51335.5, 51335.6, and 51334 and related sections of the Manual of Criteria for Medi-Cal Authorization referenced in Title 22, CCR, 51003(e).

Upon admission to an appropriate Facility, Contractor shall assess the Member's health care needs and estimate the potential length of stay of the Member. If the Member requires LTC, in the Facility for longer than the month of admission plus one month, Contractor shall submit a disenrollment request for the Member to DHS for approval. Contractor shall provide all Medically Necessary Covered Services to the Member until the disenrollment is effective.

An approved disenrollment request will become effective the first day of the second month following the month of the Member's admission to the

Facility, provided the Contractor submitted the disenrollment request at least thirty (30) days prior to that date. If the Contractor submitted the disenrollment request less than thirty (30) days prior to that date, disenrollment will be effective the first day of the month that begins at least thirty (30) days after submission of the disenrollment request. Upon the disenrollment effective date, Contractor shall ensure the Member's orderly transfer from the Contractor to the Medi-Cal Fee-For-Service program. This includes notifying the Member and his or her family or guardian of the disenrollment; assuring the appropriate transfer of medical records from the Contractor to the Medi-Cal fee-for-service provider; assuring that continuity of care is not interrupted; and, completion of all administrative work necessary to assure a smooth transfer of responsibility for the health care of the Medi-Cal beneficiary.

Admission to a nursing Facility of a Member who has elected hospice services as described in Title 22, CCR, Section 51349, does not affect the Member's eligibility for Enrollment under this Contract. Hospice services are Covered Services under this Contract and are not long term care services regardless of the Member's expected or actual length of stay in a nursing Facility.

B. Major Organ Transplants

Except for kidney transplants, major organ transplant procedures that are Medi-Cal FFS benefits are not covered under the Contract. When a Member is identified as a potential major organ transplant candidate, Contractor shall refer the Member to a Medi-Cal approved transplant center. If the transplant center Physician considers the Member to be a suitable candidate, the Contractor shall submit a Prior Authorization Request to either the San Francisco Medi-Cal Field Office (for adults) or the California Children Services Program (for children) for approval. Contractor shall initiate disenrollment of the Member when all of the following has occurred: referral of the Member to the organ transplant Facility; the Facility's evaluation has concurred that the Member is a candidate for major organ transplant; and, the major organ transplant is authorized by either DHS' Medi-Cal Field Office (for adults) or the California Children Services Program (for children).

Contractor shall continue to provide all Medically Necessary Covered Services until the Member has been disenrolled from the plan.

Upon the disenrollment effective date, Contractor shall ensure continuity of care by transferring all of the Member's medical documentation to the transplant Physician. The effective date of the disenrollment will be retroactive to the beginning of the month in which the Member was

approved as a major organ transplant candidate. The request for reimbursement for services in the month during which the transplant is approved are to be sent by the provider directly to the Medi-Cal FFS fiscal intermediary. The capitation payment for the Member will be recovered from the Contractor by DHS.

If the Member is evaluated and determined not to be a candidate for a major organ transplant or DHS denies authorization for a transplant, the Member will not be disenrolled. Contractor shall cover the cost of the evaluation performed by the Medi-Cal approved transplant center.

C. Waiver Programs

DHS administers a number of Medi-Cal Home and Community Based Services (HCBS) Waiver Programs authorized under section 1915(c) of the Social Security Act. Contractor shall have procedures in place to identify Members who may benefit from the HCBS Waiver programs, and refer them to the Medical Care Coordination and Case Management Section of DHS. These waiver programs include the In-Home Medical Care Waiver, the Nursing Facility Subacute Waiver, and the Nursing Facility Waiver. If the agency administering the waiver program concurs with Contractor's assessment of the Member and there is available placement in the waiver program, Contractor shall initiate disenrollment for the Member. Contractor shall provide documentation to ensure the Member's orderly transfer to the Medi-Cal Fee-For-Service program. If the Member does not meet the criteria for the waiver program, or if placement is not available, Contractor shall continue comprehensive case management and shall continue to cover all Medically Necessary Covered Services to the Member.

18. Immunization Registry Reporting

Contractor shall ensure that member-specific immunization information is periodically reported to an immunization registry(ies) established in the Contractor's Service Area(s) as part of the Statewide Immunization Information System. Reports shall be made following the Member's initial health assessment and all other health care visits which result in an immunization being provided. Reporting shall be in accordance with all applicable State and federal laws.

LOCAL HEALTH DEPARTMENT COORDINATION

1. Subcontracts

Contractor shall negotiate in good faith and execute a Subcontract for public health services listed in A through D below with the Local Health Department (LHD) in each county that is covered by this Contract. The Subcontract shall specify: the scope and responsibilities of both parties in the provision of services to Members; billing and reimbursements; reporting responsibilities; and how services are to be coordinated between the LHD and the Contractor, including exchange of medical information as necessary. The Subcontract shall meet the requirements contained in Exhibit A, Attachment 6, provision 13, regarding Subcontracts.

A. Family Planning Services: as specified in Exhibit A, Attachment 8, provision 9.

B. STD services for the disease episode, as specified in Exhibit A, Attachment 8, provision 10, by DHS, for each STD, including diagnosis and treatment of the following STDs: syphilis, gonorrhea, chlamydia, herpes simplex, chancroid, trichomoniasis, human papilloma virus, non-gonococcal urethritis, lymphogranuloma venereum and granuloma inguinale.

C. HIV Testing and Counseling as specified in Exhibit A, Attachment 8, provision 11.

D. Immunizations: as specified in Exhibit A, Attachment 8, provision 12.

To the extent that Contractor does not meet this requirement on or before four (4) months after award of this Contract, Contractor shall submit documentation substantiating reasonable efforts to enter into Subcontracts.

2. Subcontracts or Memoranda of Understanding

If reimbursement is to be provided for services rendered by the following programs or agencies, Contractor shall execute a subcontract with the LHD or agency as stipulated in provision 1 above. If no reimbursement is to be made, Contractor or agency shall negotiate in good faith and execute a Memorandum of Understanding (MOU) for services provided by these programs and agencies.

A. California Children Services (CCS)

B. Maternal and Child Health (MCH)

C. Child Health and Disability Prevention (CHDP) Program

D. Tuberculosis Direct Observed Therapy

E. Women, Infants, and Children (WIC) Supplemental Nutrition Program

F. Regional Centers for services for persons with developmental disabilities.

3. Local Mental Health Plan Coordination

A. Contractor shall negotiate in good faith and execute a MOU with the local mental health plan (MHP) in accordance with Welfare and Institutions Code, Section 5777.5. The MOU shall specify, consistent with this Contract, the respective responsibilities of Contractor and the MHP in delivering Medically Necessary Covered Services and Specialty Mental Health Services to Members. The MOU shall address:

1) Protocols and procedures for referrals between Contractor and the MHP;

2) Protocols for the delivery of Specialty Mental Health Services, including the MHP's provision of clinical consultation to Contractor for Members being treated by Contractor for mental illness;

3) Protocols for the delivery of mental health services within the Primary Care Physician's scope of practice;

4) Protocols and procedures for the exchange of Medical Records information, including procedures for maintaining the confidentiality of Medical Records;

5) Procedures for the delivery of Medically Necessary Covered Services to Members who require Specialty Mental Health Services, including:

a) Pharmaceutical services and prescription drugs;

b) Laboratory, radiological and radioisotope services;

c) Emergency room facility charges and professional services;

d) Emergency and non-emergency medical transportation;

e) Home health services;

f) Medically Necessary Covered Services to Members who are patients in psychiatric inpatient hospitals.

6) Procedures for transfers between inpatient psychiatric services and inpatient medical services to address changes in a Member's medical or mental health condition.

7) Procedures to resolve disputes between Contractor and the MHP.

4. MOU Monthly Reports

To the extent Contractor does not execute an MOU within four (4) months after award of this Contract, Contractor shall submit documentation substantiating its good faith efforts to enter into an MOU. Until such time as an MOU is executed, Contractor shall submit monthly reports to DHS documenting its continuing good faith efforts to execute an MOU and the justifications why such an MOU has not been executed.

MEMBER SERVICES

1. Members Rights And Responsibilities

A. Member Rights and Responsibilities

Contractor shall develop, implement and maintain written policies that address the Member's rights and responsibilities and shall communicate these to its Members, and providers.

1) Contractor's written policies regarding Member rights shall include the following:

a) to be treated with respect, giving due consideration to the Member's right to privacy and the need to maintain confidentiality of the Member's medical information.

b) to be provided with information about the organization and its services.

c) to be able to choose a Primary Care Provider within the Contractor's network.

d) to participate in decision making regarding their own health care, including the right to refuse treatment.

e) to voice grievances, either verbally or in writing, about the organization or the care received.

f) to receive oral interpretation services for their language.

g) to formulate advance directives.

h) to have access to family planning services, Federally Qualified Health Centers, Indian Health Service Facilities, sexually transmitted disease services and Emergency Services outside the Contractor's network pursuant to the federal law.

i) to request a state Medi-Cal fair hearing, including information on the circumstances under which an expedited fair hearing is possible.

j) to have access to, and where legally appropriate, receive copies of, amend or correct their Medical Record,

k) to disenroll upon request.

l) to access minor consent services.

m) to receive written Member informing materials in alternative formats, including Braille and large size print upon request.

n) to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation,

o) to receive information on available treatment options and alternatives, presented in a manner appropriate to the Member's condition and ability to understand.

p) Freedom to exercise these rights without adversely affecting how they are treated by the Contractor, providers, or the State.

2) Contractor's written policy regarding Member responsibilities shall include providing accurate information to the professional staff, following instructions, and cooperating with the providers.

B. Members' Right to Confidentiality

Contractor shall implement and maintain policies and procedures to ensure the Members' right to confidentiality of medical information.

1) Contractor shall ensure that Facilities implement and maintain procedures that guard against disclosure of confidential information to unauthorized persons inside and outside the network.

2) Contractor shall counsel Members on their right to confidentiality and Contractor shall obtain Member's consent prior to release of confidential information, unless such consent is not required pursuant to Title 22, CCR, Section 51009.

C. Members' Rights to Advance Directives

Contractor shall implement and maintain written policies and procedures respecting advance directives in accordance with the requirements of 42 CFR 422.128 and 42 CFR 438.6(i).

2. Member Services Staff

A. Contractor shall maintain the capability to provide Member services to Medi-Cal Members through sufficient assigned and knowledgeable staff.

B. Contractor shall ensure Member services staff are trained on all contractually required Member service functions including, policies, procedures, and scope of benefits of this Contract.

3. Call Center Reports

Contractor shall report quarterly, in a format to be approved by DHS, the number of calls received by call type (questions, grievances, access to services, request for health education, etc.); the average speed to answer Member services telephone calls with a live voice; and, the Member services telephone calls abandonment rate.

4. Written Member Information

A. Contractor shall provide all new Medi-Cal Members, and Potential Enrollees upon request only, with written Member information as specified in Title 22, CCR, Section 53895. Compliance with items required by Section 53895(b) may be met through distribution of the Member Services Guide.

The Member Services Guide shall meet the requirements of an Evidence of Coverage and Disclosure Form (EOC/DF) as stipulated by Title 28, CCR, Sections 1300.51 (d), Exhibit T (EOC) or U (Combined EOC/DF) and Title 22, CCR, Section 53881. In addition, the Member Services Guide shall meet the requirements contained in Health and Safety Code, Section 1363, and Title 28, CCR, Section 1300.63(a), as to print size, readability, and understandability of text.

B. Contractor shall distribute the Member information no later than seven (7) days after the effective date of the Member's Enrollment. Contractor shall revise this information, if necessary, and distribute it annually to each Member or family unit.

C. Contractor shall ensure that all written Member information is provided to Members at a sixth grade reading level or as determined appropriate through the Contractor's group needs assessment and approved by DHS. The written Member information shall ensure Members' understanding of the health plan processes and ensure the Member's ability to make informed health decisions.

Written Member-informing materials shall be translated into the identified threshold and concentration languages discussed in Exhibit A, Attachment 9, provision 13, regarding Linguistic Services.

Upon request from a visually impaired Member, written Member materials in either Braille or a format utilizing a size fourteen (14) type font shall be provided.

D. Contractor shall develop and provide each Member, or family unit, a Member Services Guide that constitutes a fair disclosure of the provisions of the covered health care services. The Member Services Guide shall be submitted to DHS for review prior to distribution to Members. The Member Services Guide shall include the following information:

1) The plan name, address, telephone number and service area covered by the health plan.

2) A description of the full scope of Medi-Cal Managed Care covered benefits and all available services including health education, interpretive services provided by plan personnel and at service sites, and "carve out" services and an explanation of any service limitations and exclusions from coverage or charges for services. Include information and identification of services to which the Contractor or subcontractor has a moral objection to perform or support.

3) Procedures for accessing Covered Services including that Covered Services shall be obtained through the plan's providers unless otherwise allowed under this Contract.

   A description of the Member identification card issued by the Contractor, if applicable, and an explanation as to its use in authorizing or assisting Members to obtain services.

4) Compliance with the following may be met through distribution of a provider directory:

   The address and telephone number of each Service Location (e.g., locations of hospitals, Primary Care Physicians (PCP), optometrists, psychologists, pharmacies, Skilled Nursing Facilities, Urgent Care Facilities, FQHCs, Indian Health Centers). In the case of a medical group/foundation or independent practice association (IPA), the medical group/foundation or IPA name, address and telephone number shall appear for each Physician provider:

   The hours and days when each of these Facilities is open, the services and benefits available, and the telephone number to call after normal business hours.

5) Procedures for selecting or requesting a change in PCP at any time; any requirements that a Member would have to change PCP; reasons for which a request for a specific PCP may be denied; and reasons why a provider may request a change.

6) The purpose and value of scheduling an initial health assessment appointment.

7) The appropriate use of health care services in a managed care system.

8) The availability and procedures for obtaining after hours services (24-hour basis) and care, including the appropriate provider

locations and telephone numbers. This shall include an explanation of the Members' right to interpretive services, at no cost, to assist in receiving after hours services.

9) Procedures for obtaining emergency health care from specified plan providers or from non-plan providers, including outside Contractor's Service Area.

10) Process for referral to specialists in sufficient detail so Member can understand how the process works, including timeframes.

11) Procedures for obtaining any transportation services to Service Sites that are offered by Contractor or available through the Medi-Cal program, and how to obtain such services. Include a description of both medical and non-medical transportation services and the conditions under which non-medical transportation is available.

12) Procedures for filing a grievance with Contractor, either orally or in writing, including procedures for appealing decisions regarding Member's coverage, benefits, or relationship to the organization or other dissatisfaction with the Contractor and/or providers. Include the title, address, and telephone number of the person responsible for processing and resolving grievances and responsible for providing assistance completing the request. Information regarding the process shall include the requirements and the timelines for the Contractor to acknowledge receipt of grievances, to resolve grievances, and to notify the Member of the resolution of grievances or appeals. Information shall be provided informing the Member how to request continuation of service(s) previously authorized by the Contractor, while the grievance is being resolved.

13) The causes for which a Member shall lose entitlement to receive services under this Contract as stipulated in Exhibit A, Attachment 16, provision 3. Disenrollment.

14) Procedures for Disenrollment, including an explanation of the Member's right to disenroll without cause at any time, subject to any restricted disenrollment period.

15) Information on the Member's right to the Medi-Cal fair hearing process and information on the circumstances under which an expedited fair hearing is possible and information regarding assistance in completing the request, regardless of whether or not a grievance has been submitted or if the grievance has been

resolved, pursuant to Title 22, CCR, Section 53452, when a health care service requested by the Member or provider has been denied, deferred or modified. Information on State Fair Hearing shall also include information on the timelines which govern a Member's right to a State Fair Hearing, pursuant to Welfare & Institutions Code §10951 and the State Department of Social Services' Public Inquiry and Response Unit toll-free telephone number (1-800-952-5253) to request a state hearing.

16) Information on the availability of, and procedures for obtaining, services at FQHCs and Indian Health Clinics.

17) Information on the Member's right to seek family planning services from any qualified provider of family planning services under the Medi-Cal program, including providers outside Contractor's provider network, how to access these services, and a description of the limitations on the services that Members may seek outside the plan. Contractor may use the following statement:

Family planning services are provided to Members of childbearing age to enable them to determine the number and spacing of children. These services include all methods of birth control approved by the Federal Food and Drug Administration. As a Member, you pick a doctor who is located near you and will give you the services you need. Our Primary Care Physicians and OB/GYN specialists are available for family planning services. For family planning services, you may also pick a doctor or clinic not connected with [Plan Name (Contractor)] without having to get permission from [Plan Name (Contractor)]. [Plan Name (Contractor)] shall pay that doctor or clinic for the family planning services you get.

18) Procedures for providing female Members with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the Member's designated source of primary care if that source is not a woman's health specialist.

19) DHS' Office of Family Planning toll-free telephone number (1-800-942-1054) providing consultation and referral to family planning clinics.

20) Information on the availability of, and procedures for obtaining, Certified Nurse Midwife and Certified Nurse Practitioner services,

pursuant to Exhibit A, Attachment 9, provision 7, on Nurse Midwife and Nurse Practitioner Services.

21) Information on the availability of transitional Medi-Cal eligibility and how the Member may apply for this program. Contractor shall include this information with all Member Service Guides sent to Members after the date such information is furnished to Contractor by DHS.

22) Information on how to access State resources for investigation and resolution of Member complaints, including a description of the DHS Medi-Cal Managed Care Ombudsman Program and toll-free telephone number (1-888-452-8609), and the Department of Managed Health Care, Health Maintenance Organization (HMO) Consumer Service toll-free telephone number (1-800-400-0815).

23) Information concerning the provision and availability of services covered under the CCS program from providers outside Contractor's provider network and how to access these services.

24) An explanation of the expedited Disenrollment process for Members qualifying under conditions specified under Title 22, CCR, Section 53889(j) which includes children receiving services under the Foster Care or Adoption Assistance Programs; Members with special health care needs, including, but not limited to major organ transplants; and Members already enrolled in another Medi-Cal, Medicare or commercial managed care plan.

25) Information on how to obtain Minor Consent Services through Contractor's provider network, an explanation of those services, and information on how they can also be obtained out of the Contractor's provider network.

26) An explanation on how to use the Fee-For-Service system when Medi-Cal covered services are excluded or limited under this Contract and how to obtain additional information.

27) An explanation of an American Indian Member's right to not enroll in a Medi-Cal Managed Care plan, to be able to access Indian Health Service facilities, and to disenroll from Contractor's plan at any time, without cause.

28) A notice regarding the positive benefits of organ donations and how a Member can become an organ or tissue donor. Pursuant to California Health and Safety Code, Section 7158.2, this notice must

be provided upon enrollment and annually thereafter in the evidence of coverage (Member Services Guide), health plan newsletter or any other direct communication with Members.

29) A statement as to whether the Contractor uses provider financial bonuses or other incentives with its contracting providers of health care services and that the Member may request additional information about these bonuses or incentives from the plan, the Member's provider or the provider's medical group or independent practice association, pursuant to California Health and Safety Code, Section 1367.10.

30) A notice as to whether the Contractor uses a drug formulary. Pursuant to California Health and Safety Code, Section 1363.01, the notice shall: (1) be in the language that is easily understood and in a format that is easy to understand; (2) include an explanation of what a formulary is, how the plan decides which prescription drugs are included in or excluded from the formulary, and how often the formulary is updated; (3) indicate that the Member can request information regarding whether a specific drug is on the formulary and the telephone number for requesting this information; and (4) indicate that the presence of a drug on the plan's formulary does not guarantee that a Member will be prescribed that drug by his or her prescribing provider for a particular medical condition.

31) Policies and procedures regarding a Members' right to formulate advance directives. This information shall include the Member's right to be informed by the Contractor of California state law regarding advance directives, and to receive information from the Contractor regarding any changes to that law. The information shall reflect changes in state law regarding advance directives as soon as possible, but no later than 90 days after the effective date of change.

32) Any other information determined by DHS to be essential for the proper receipt of Covered Services.

E. Member Identification Card

Contractor shall provide an identification card to each Member, which identifies the Member and authorizes the provision of Covered Services to the Member. The card shall specify that Emergency Services rendered to the Member by non-Contracting providers are reimbursable by the Contractor without Prior Authorization.

5. Notification of Changes in Access to Covered Services

Contractor shall ensure Medi-Cal Members are notified in writing of any changes in the availability or location of Covered Services, or any other changes in information listed in 42 CFR 438.10(f(6))-(h), at least thirty (30) days prior to the effective date of such changes. In cases of unforeseeable circumstances, notice shall be given within fourteen (14) days prior to the change unless DHS determines that post-change notification is appropriate. In this latter instance, notice to Members shall be provided within fourteen (14) days subsequent to the change. The notification must also be presented to and approved in writing by DHS prior to its' release.

6. Primary Care Provider Selection

A. Contractor shall implement and maintain DHS approved procedures to ensure that each new Member has an appropriate and available Primary Care Physician. Contractor shall provide each new Member an opportunity to select a Primary Care Physician within the first thirty (30) days of enrollment. If the Contractor's provider network includes nurse practitioners, certified nurse midwives, or physician assistants, the Member may select a nurse practitioner, certified nurse midwife, or physician assistant within thirty (30) days of enrollment to provide Primary Care services in accordance with Title 22, CCR, Section 53853(a)(4). Contractor shall ensure that Members are allowed to change a Primary Care Physician, nurse practitioner, certified nurse midwife or physician assistant, upon request, by selecting a different Primary Care Provider from Contractor's network of providers.

B. Contractor shall disclose to affected Members any reasons for which their selection or change in Primary Care Physician could not be made.

C. Contractor shall ensure that Members with an established relationship with a provider in Contractor's network, who have expressed a desire to continue their patient/provider relationship, are assigned to that provider without disruption in their care.

D. Contractor shall ensure that Members may choose traditional and safety net providers as their Primary Care Provider.

7. Primary Care Provider Assignment

A. If the Member does not select a Primary Care Provider within thirty (30) days of the effective date of enrollment, Contractor shall assign that Member to a Primary Care Provider and notify the Member and the assigned Primary Care Provider no later than forty (40) days after the

Member's Enrollment. Contractor shall ensure that adverse selection does not occur during the assignment process of Members to providers.

B. Contractor shall notify the Primary Care Provider that a Member has selected or been assigned to the provider within seven (7) days from when selection or assignment is completed by the Member or the Contractor, respectively.

C. Contractor shall maintain procedures that proportionately include contracting traditional and safety-net providers in the assignment process for Members who do not choose a Primary Care Provider.

8. Denial, Deferral, or Modification of Prior Authorization Requests

A. Contractor shall notify Members of a decision to deny, defer, or modify requests for Prior Authorization, in accordance with Title 22, CCR, Sections 51014.1 and 53894 by providing written notification to Members and/or their authorized representative, regarding any denial, deferral or modification of a request for approval to provide a health care service. This notification must be provided as specified in Title 22, CCR, Sections 51014.1, 51014.2, 53894, and Health and Safety Code Section 1367.01.

B. Contractor shall provide for a written notification to the Member and the Member's representative on a standardized form informing the Member of all the following:

1) The Member's right to, and method of obtaining, a fair hearing to contest the denial, deferral, or modification action and the decision the Contractor has made.

2) The Member's right to represent himself/herself at the fair hearing or to be represented by legal counsel, friend or other spokesperson.

3) The name and address of Contractor and the State toll-free telephone number for obtaining information on legal service organizations for representation.

C. Contractor shall provide required notification to beneficiaries and their authorized representatives in accordance with the time frames set forth in Title 22, CCR, Sections 51014.1 and 53894. Such notice shall be deposited with the United States Postal Service in time for pick-up no later than the third working day after the decision is made, not to exceed 14 calendar days from receipt of the original request. If the decision is deferred because an extension is requested or justified as explained in

Exhibit A, Attachment 5, provision 3, Contractor shall notify the Member in writing of the deferral of the decision no later than 14 calendar days from the receipt of the original request. If the final decision is to deny or modify the request, Contractor shall provide written notification of the decision to Members no later than 28 calendar days from the receipt of the original request.

If the decision regarding a prior authorization request is not made within the time frames indicated in Exhibit A, Attachment 5, provision 3, the decision is considered denied and notice of the denial must be sent to the Member on the date the time frame expires.

MEMBER GRIEVANCE SYSTEM

1. Member Grievance System

Contractor shall implement and maintain a Member Grievance system in accordance with Title 28, CCR, Section 1300.68 and 1300.68.01, Title 22, CCR, Section 53858, Exhibit A, Attachment 13, provision 4, paragraph D, item 12), and 42 CFR 438.420(a)-(c).

2. Grievance System Oversight

Contractor shall implement and maintain procedures as described below to monitor the Member's Grievance system and the expedited review of grievances required under Title 28, CCR, Sections 1300.68 and 1300.68.01 and Title 22, CCR, Section 53858.

A. Procedure to ensure timely resolution and feedback to complainant. Provide oral notice of the resolution of an expedited review.

B. Procedure for systematic aggregation and analysis of the grievance data and use for Quality Improvement.

C. Procedure to ensure that the grievance submitted is reported to an appropriate level, i.e., medical issues versus health care delivery issues. To this end, Contractor shall ensure that any grievance involving the appeal of a denial based on lack of medical necessity, appeal of a denial of a request for expedited resolution of a grievance, or an appeal that involves clinical issues shall be resolved by a health care professional with appropriate clinical expertise in treating the Member's condition or disease.

D. Procedure to ensure that requirements of Title 22 CCR Section 51014.2 are met regarding services to Members during the grievance process.

E. Procedure to ensure that the person making the final decision for the proposed resolution of a grievance has not participated in any prior decisions related to the grievance.

F. Procedures to ensure that Members are given a reasonable opportunity to present, in writing or in person before the individual(s) resolving the grievance, evidence, facts and law in support of their grievance. In the case of a grievance subject to expedited review, Contactor shall inform the Member of the limited time available to present evidence. Contractor shall also comply with 42 CFR 438.406(b)(3) concerning a Member's request to review records in connection with a grievance.

3. Quarterly Grievance Log and Report

A. Contractor shall maintain grievance logs, including copies of grievance logs of any sub-contracting entity delegated the responsibility to maintain and resolve grievances. Grievance logs shall include all the required information set forth in Title 22, CCR, Section 53858(e).

B. Contractor shall submit the quarterly grievance report for Medi-Cal Members only in the form that is required by and submitted to the DMHC as set forth in Title 28, CCR, Section 1300.68(f).

1) In addition to the types or nature of grievances listed in Title 28, CCR, Section 1300.68(f)(2)((D), the report shall also include, but not be limited to, timely assignments to a provider, issues related to cultural and linguistic sensitivity, and difficulty with accessing specialists.

2) For the Medi-Cal category of the report, provide the following additional information on each grievance: timeliness of responding to the Member, geographic region, ethnicity, gender, primary language of the Member, and final outcome of the grievance.

C. Contractor shall submit the quarterly grievance report for Medi-Cal Members the following quarters: April – June, July –September, October – December, January – March. The report is due 30 calendar days from the date of the end of the reporting quarter.

4. Responsibilities in Expedited State Fair Hearings

Within two (2) business days of being notified by DHS or the Department of Social Services (DSS) that a Member has filed a request for fair hearing which meets the criteria for expedited resolution, Contractor shall deliver directly to the designated/appropriate DSS administrative law judge all information and documents which either support, or which the Contractor considered in connection with, the action which is the subject of the expedited fair hearing. This includes, but is not necessarily limited to, copies of the relevant treatment authorization request and notice of action (NOA), plus any pertinent grievance resolution notice. If the NOA or grievance resolution notice are not in English, fully translated copies shall be transmitted to DSS along with copies of the original NOA and grievance resolution notice. One or more plan representatives with knowledge of the Member's condition and the reason(s) for the action, which is the subject of the expedited fair hearing, shall be available by phone during the scheduled fair hearing.

MARKETING

1. Training and Certification of Marketing Representatives

If Contractor conducts Marketing, Contractor shall develop a training and certification program for Marketing Representatives and ensure that all staff performing Marketing activities or distributing Marketing material are appropriately certified.

A. Contractor is responsible for all Marketing activity conducted on behalf of the Contractor. Contractor will be held liable for any and all violations by any Marketing Representatives. Marketing staff may not provide Marketing services for more than one Contractor. Marketing Representatives shall not engage in Marketing practices that discriminate against an Eligible Beneficiary or Potential Enrollee because of race, creed, language, age, color, sex, religion, national origin, ancestry, marital status, sexual orientation, physical or mental handicap, or health status.

B. Training Program

Contractor shall develop a training program that will train staff and prepare Marketing Representatives for certification. Contractor shall develop a staff orientation and Marketing representative's training/certification manual. The manual shall, at a minimum, cover the following topics:

1) An explanation of the Medi-Cal Program, including both FFS and capitated contractors, and eligibility.

2) Scope of Services

3) An explanation of the Contractor's administrative operations and health delivery system program, including the Service Area covered, excluded services, additional services, conditions of enrollment and aid categories.

4) An explanation of Utilization Management (how the beneficiary is obligated to obtain all non-emergency medical care through the Contractor's provider network and describing all precedents to receipt of care like referrals, prior authorizations, etc.).

5) An explanation of the Contractor's grievance procedures.

6) An explanation of how to fill out an enrollment form.

7) An explanation of how a beneficiary disenrolls from the Contractor and conditions for both voluntary and mandatory disenrollment reasons.

8) An explanation of the requirements of confidentiality of any information obtained from Medi-Cal beneficiaries including information regarding eligibility under any public welfare or social services program.

9) An explanation of how Marketing Representatives will be supervised and monitored to assure compliance with regulations.

10) An explanation of acceptable communication and sales techniques. This shall include an explanation of prohibited Marketing Representative activities and conduct.

11) An explanation that discrimination in enrollment and failure to enroll a beneficiary due to a pre-existing medical condition (except for conditions requiring contract-excluded services) are illegal.

12) An explanation of the consequences of misrepresentation and Marketing abuses (i.e., discipline, suspension of Marketing, termination, civil and criminal prosecution, etc.). The Marketing Representative must understand that any abuse of Marketing requirements can also cause the termination of the Contractor's contract with the State.

2. DHS Approval

A. Contractor shall not conduct Marketing activities presented in provision 3, paragraph A, subparagraph 2), item d) below, without written approval of its Marketing plan, or changes to its Marketing plan, from DHS. In cases where the Contractor wishes to attend a location or conduct an activity not included in provision 3, paragraph A, subparagraph 2), items c) and d) below, Contractor shall submit a request to include the activity and obtain written, prior approval from DHS, pursuant to provision 4. Marketing Event Notification below.

B. All Marketing materials, and changes in Marketing materials, including but not limited to, all printed materials, illustrated materials, videotaped and media scripts, shall be approved in writing by DHS prior to distribution.

C. Contractor's training and certification program and changes in the training and certification program shall be approved in writing by DHS prior to implementation.

3. Marketing Plan

If Contractor conducts Marketing, Contractor shall develop a Marketing plan as specified below. Contractor shall implement and maintain the Marketing plan only after approval from DHS. Contractor shall ensure that the Marketing plan, all procedures and materials are accurate and do not mislead, confuse or defraud.

A. Contractor shall submit a Marketing plan to DHS for review and approval on an annual basis. The Marketing plan, whether new, revised, or updated, shall describe the Contractor's current Marketing procedures, activities, and methods. No Marketing activity shall occur until the Marketing plan has been approved by DHS.

1) The Marketing plan shall have a table of contents section that divides the Marketing plan into chapters and sections. Each page shall be dated and numbered so chapters, sections, or pages, when revised, can be easily identified and replaced with revised submissions.

2) Contractor's Marketing plan shall contain the following items and exhibits:

a) Mission Statement or Statement of Purpose for the Marketing plan.

b) Organizational Chart and Narrative Description

The organizational chart shall include the Marketing director's name, address, telephone and facsimile number and key staff positions.

The description shall explain how the Contractor's internal Marketing department operates, identifying key staff positions, roles and responsibilities, and, reporting relationships including, if applicable, how the Contractor's commercial Marketing staff and functions interface with its Medi-Cal Marketing staff and functions.

c) Marketing Locations

All sites for proposed Marketing activities such as annual health fairs, and community events, in which the Contractor proposes to participate, shall be listed.

d) Marketing Activities

All Marketing methods and Marketing activities Contractor expects to use, or participate in, shall be described. Contractor shall comply with the guidelines described in Title 22, CCR, Sections 53880 and 53881, Welfare and Institutions Code, Sections 10850(b), 14407.1, 14408, 14409, 14410, and 14411, and as follows:

i. Contractor shall not engage in door to door or cold call Marketing for the purpose of enrolling Members or Potential Enrollees, or for any other purpose.

ii. Contractor shall obtain DHS approval to perform in-home Marketing presentations and shall provide strict accountability, including documentation of the prospective Member's request for an in-home Marketing presentation or a documented telephone log entry showing the request was made.

iii. Contractor shall not conduct Marketing presentations at primary care sites.

iv. Include a letter or other document that verifies cooperation or agreement between the Contractor and an organization to undertake a Marketing activity together and certify or otherwise demonstrate that permission for use of the Marketing activity/event site has been granted.

e) Marketing Materials

Copies of all Marketing materials the Contractor will use for both English and non-English speaking populations shall be included.

A sample copy of the Marketing identification badge and business card that will clearly identify Marketing Representatives as employees of the Contractor shall be included. Marketing identification badges and business cards shall not resemble those of a government agency.

f) Marketing Distribution Methods

A description of the methods the Contractor will use for distributing Marketing materials.

g) Monitoring and Reporting Activities

Written formal measures to monitor performance of Marketing Representatives to ensure Marketing integrity pursuant to Welfare and Institutions Code, Section 14408(c).

h) Miscellaneous

All other information requested by DHS to assess the Contractor's Marketing program.

B. Contractor shall not seek to influence enrollment in conjunction with the sale or offering of any private insurance.

4. Marketing Event Notification

Contractor shall notify DHS at least thirty (30) days in advance of Contractor's participation in all Marketing events. In cases where Contractor learns of an event less than 30 days in advance, Contractor shall provide notification to DHS immediately. In no instance shall notification be less than 48 hours prior to the event.

ENROLLMENTS AND DISENROLLMENTS

1. Enrollment Program

Contractor shall cooperate with the DHS Enrollment program and shall provide to DHS' enrollment contractor a list of network providers (provider directory), linguistic and cultural capabilities of the Contractor and other information deemed necessary by DHS to assist Medi-Cal beneficiaries, and Potential Enrollees, in making an informed choice in health plans. The provider directory will be submitted every six (6) months and in accordance with MMCD Policy Letter 00-02.

2. Enrollment

Contractor shall accept as Members Medi-Cal beneficiaries in the mandatory and voluntary aid categories as defined in Exhibit E, Attachment 1, Definitions, provision 30, Eligible Beneficiaries, including Medi-Cal beneficiaries in Aid Codes who elect to enroll with the Contractor or are assigned to the Contractor.

A. Enrollment - General

Eligible Beneficiaries residing within the Service Area of Contractor may be enrolled at any time during the term of this Contract. Eligible Beneficiaries shall be accepted by Contractor in the order in which they apply without regard to physical or mental condition, age, sex, race, religion, creed, color, national origin, marital status, sexual orientation or ancestry.

B. Coverage

Member coverage shall begin at 12:01 a.m. on the first day of the calendar month for which the Eligible Beneficiary's name is added to the approved list of Members furnished by DHS to Contractor. The term of enrollment shall continue indefinitely unless this Contract expires, is terminated, or the Member is disenrolled under the conditions described in provision 3, Disenrollment.

C. Exception to Enrollment

A Member in a mandatory aid code category is not required to enroll when a request for an exemption under Title 22, CCR, Section 53887 has been approved.

D. Enrollment Restriction

Enrollment will proceed unless restricted by DHS. Such restrictions will be defined in writing and the Contractor notified at least ten (10) days prior to the start of the period of restriction. Release of restrictions will be in writing and transmitted to the Contractor at least ten (10) days prior to the date of the release.

3. Disenrollment

The enrollment contractor shall process a Member Disenrollment under the following conditions, subject to approval by DHS, in accordance with the provisions of Title 22, CCR, Section 53891:

A. Disenrollment of a Member is mandatory when:

1) The Member requests Disenrollment, subject to any lock-in restrictions on Disenrollment under the federal lock-in option, if applicable.

2) The Member's eligibility for Enrollment with Contractor is terminated or eligibility for Medi-Cal is ended, including the death of the Member.

3) Enrollment was in violation of Title 22, CCR, Sections 53891(a)(2), or requirements of this Contract regarding Marketing, and DHS or Member requests Disenrollment.

4) Disenrollment is requested in accordance with Welfare and Institutions Code, Sections 14303.1 regarding merger with other organizations, or 14303.2 regarding reorganizations or mergers with a parent or subsidiary corporation.

5) There is a change of a Member's place of residence to outside Contractor's Service Area.

6) Disenrollment is based on the circumstances described in Exhibit A, Attachment 11, provision 17, regarding Excluded Services Requiring Member Disenrollment.

Such Disenrollment shall become effective on the first day of the second month following receipt by DHS of all documentation necessary, as determined by DHS, to process the Disenrollment, provided Disenrollment was requested at least thirty (30) days prior to that date, except for Disenrollments pursuant to Exhibit A, Attachment 11, provision 17,

regarding Major Organ Transplants, for which Disenrollment shall be effective the beginning of the month in which the transplant is approved.

B. Contractor may recommend to DHS the Disenrollment of any Member in the event of a breakdown in the "Contractor/Member relationship" which makes it impossible for Contractor's providers to render services adequately to a Member. Except in cases of violent behavior or fraud, Contractor shall make, and document, significant efforts to resolve the problem with the Member through avenues such as reassignment of Primary Care Physician, education, or referral to services (such as mental health or substance abuse programs), before requesting a Contractor-initiated Disenrollment. In cases of Contractor-initiated Disenrollment of a Member, Contractor must submit to DHS a written request with supporting documentation for Disenrollment based on the breakdown of the "Contractor/Member relationship." Contractor-initiated Disenrollments must be prior approved by DHS and shall be considered only under any of the following circumstances:

1) Member is repeatedly verbally abusive to contracting providers, ancillary or administrative staff, subcontractor staff or to other plan Members.

2) Member physically assaults a Contractor's staff person, subcontracting provider or staff person, or other Member, or threatens another individual with a weapon on Contractor's premises or subcontractor's premises. In this instance, Contractor or subcontractor shall file a police or security agency report and file charges against the Member.

3) Member is disruptive to Contractor operations, in general.

4) Member habitually uses providers not affiliated with Contractor for non-Emergency Services without required authorizations (causing Contractor to be subjected to repeated provider demands for payment for those services or other demonstrable degradation in Contractor's relations with community providers).

5) Member has allowed the fraudulent use of Medi-Cal coverage under the plan, which includes allowing others to use the Member's plan identification card to receive services from Contractor.

C. A Member's failure to follow prescribed treatment (including failure to keep established medical appointments) shall not, in and of itself, be good cause for the approval by DHS of a Contractor-initiated Disenrollment request unless Contractor can demonstrate to DHS that, as a result of the

failure, Contractor is exposed to a substantially greater and unforeseeable risk than that otherwise contemplated under the Contract and rate-setting assumptions.

D. The problem resolution attempted prior to a Contractor-initiated Disenrollment described in paragraph B, must be documented by Contractor. A formal procedure for Contractor-initiated Disenrollments shall be established by Contractor and approved by DHS. As part of the procedure, the Member shall be notified in writing by Contractor of the intent to disenroll the Member for cause and allowed a period of no less than twenty (20) days to respond to the proposed action.

1) Contractor must submit a written request for Disenrollment and the documentation supporting the request to DHS for approval. The supporting documentation must establish the pattern of behavior and Contractor's efforts to resolve the problem. DHS shall review the request and render a decision in writing within ten (10) State working days of receipt of a Contractor request and necessary documentation. If the Contractor-initiated request for Disenrollment is approved by DHS, DHS shall submit the Disenrollment request to the enrollment contractor for processing. Contractor shall be notified by DHS of the decision, and if the request is granted, shall be notified by the enrollment contractor of the effective date of the Disenrollment. Contractor shall notify the Member of the Disenrollment for cause if DHS grants the Contractor-initiated request for Disenrollment.

2) Contractor shall continue to provide Covered Services to the Member until the effective date of the Disenrollment.

E. Except as provided in paragraph A, subparagraph 6, enrollment shall cease no later than midnight on the last day of the first calendar month after the Member's Disenrollment request and all required supporting documentation are received by DHS. On the first day after enrollment ceases, Contractor is relieved of all obligations to provide Covered Services to the Member under the terms of this Contract. Contractor agrees in turn to return to DHS any capitation payment forwarded to Contractor for persons no longer enrolled under this Contract.

F. Contractor shall implement and maintain procedures to ensure that all Members requesting Disenrollment or information regarding the Disenrollment process are immediately referred to the enrollment contractor.

REPORTING REQUIREMENTS

Contract Section	Requirement	Frequency
Exhibit A - SCOPE OF WORK		
Attachment 1 ORGANIZATION AND ADMINISTRATION OF THE PLAN		
2. A. Key Personnel (Disclosure Form)	Key Personnel (Disclosure Form)	Annually
Attachment 2 FINANCIAL INFORMATION		
2. Financial Audit Reports B. 1	Annual "Orange Blank" Report	Annually
2. Financial Audit Reports B. 2	Fiscal Quarterly Financial Reports	Quarterly
3. Monthly Financial Statements	Monthly Financial Statements (If deemed necessary)	Monthly
Attachment 3 MANAGEMENT INFORMATION SYSTEM		
2. Encounter Date Submittal 3rd paragraph	Encounter Data Submittal	Monthly
Attachment 4 QUALITY IMPROVEMENT SYSTEM (QIS)		
4. Quality Improvement Committee 3rd paragraph	Quality Improvement Committee meeting minutes	Quarterly
8. Quality Improvement Annual Report	Quality Improvement Annual Report	Annually
9. External Quality Review Requirements A. External Accountability Set (EAS) Performance Measures 2nd paragraph	EAS Performance Measurement Rates	Annually
10. Site Review E. Data Submission	Site Review Data	Semi-Annually
Attachment 6 PROVIDER NETWORK		
10. Provider Network Report	Provider Network Report	Quarterly
11. Plan Subcontractors	Plan Subcontractors Report	Quarterly
Attachment 8 PROVIDER COMPENSATION ARRANGEMENTS		
Claims Processing D.	Claims Payment Summary Report	Quarterly
Attachment 9 ACCESS AND AVAILABILITY		
12. Cultural and Linguistic Program C. Group Needs Assessment 3.	Group Needs Assessment	Every 5 years
Attachment 10 SCOPE OF SERVICES		
4. Services for Members under Twenty-One (21) Years of Age B. Children's Preventive Services 5	Confidential Screening/ Billing Report form,PM 160-PHP	Monthly

Contract Section	Requirement	Frequency
7. Services for All Members F. Pharmaceutical Services and Provision of Prescribed Drugs 2.	Report of Changes to the Formulary	Annually
Attachment 12 LOCAL HEALTH DEPARTMENT COORDINATION 4. MOU Monthly Report	Local Health Department - MOU's Local Mental Health - MOU's (If deemed necessary)	Monthly
Attachment 13 MEMBER SERVICES 3. Call Center Report 4. Written Member Information B.	Call Center Report Member Services Guide	Quarterly Annually
Attachment 14 MEMBER GRIEVANCE SYSTEM 3. Quarterly Grievance Log and Report	Grievance Report	Quarterly
Attachment 15 MARKETING 3. Marketing Plan A.	Marketing Plan	Annually
Attachment 16 ENROLLMENTS AND DISENROLLMENTS 1. Enrollment Program (Policy Letter 00-02)	Provider Directory	Semi-Annually
Exhibit B – BUDGET DETAIL AND PAYMENT PROVISIONS 12. Payment of Aids Beneficiary Rates A. Compensation at the AIDS Beneficiary Rate (ABR) 1. C.	AIDS Beneficiaries Rate (ABR) Invoice	Monthly
Exhibit E – Additional Provisions		
Attachment 2 GENERAL TERMS AND CONDITIONS 23. Cost Avoidance and Post-Payment Recovery of Other Health Coverage Sources (OHCS) F. Reporting Requirements 1)	Post-Payment Recoveries Reports	Monthly

Exhibit B
Budget Detail and Payment Provisions

Table of Contents

Exhibit B
Budget Detail and Payment Provisions

1. Budget Contingency Clause

A. It is mutually agreed that if the Budget Act of the current year and/or any subsequent years covered under this Agreement does not appropriate sufficient funds for the program, this Agreement shall be of no further force and effect. In this event, the State shall have no liability to pay any funds whatsoever to Contractor or to furnish any other considerations under this Agreement and Contractor shall not be obligated to perform any provisions of this Agreement.

B. If funding for any fiscal year is reduced or deleted by the Budget Act for purposes of this program, the State shall have the option to either cancel this Agreement with no liability occurring to the State, or offer an agreement amendment to Contractor to reflect the reduced amount.

2. Amounts Payable

The maximum amounts payable under this agreement shall not exceed:

A. $ _____ for the 1995-96 Fiscal Year ending June 30, 1996.
B. $ _____ for the 1996-97 Fiscal Year ending June 30, 1997.
C. $ _____ for the 1997-98 Fiscal Year ending June 30, 1998.
D. $ _____ for the 1998-99 Fiscal Year ending June 30, 1999.
E. $ _____ for the 1999-00 Fiscal Year ending June 30, 2000.
F. $ _____ for the 2000-01 Fiscal Year ending June 30, 2001.
G. $ _____ for the 2001-02 Fiscal Year ending June 30, 2002.
H. $ _____ for the 2002-03 Fiscal Year ending June 30, 2003.
I. $ _____ for the 2003-04 Fiscal Year ending June 30, 2004.

The maximum amount payable for this Contract will not exceed $ _____

3. Contractor Risk In Providing Services

Contractor will assume the total risk of providing the Covered Services on the basis of the periodic capitation payment for each Member, except as otherwise allowed in this Contract. Any monies not expended by the Contractor after having fulfilled obligations under this Contract will be retained by the Contractor.

4. Capitation Rates

A. DHS shall remit to Contractor a capitation payment each month for each Medi-Cal Member that appears on the approved list of Members supplied to Contractor by DHS. The capitation rate shall be the amount specified below. The payment period for health care services shall commence on

Exhibit B
Budget Detail and Payment Provisions

the first day of operations, as determined by DHS. Capitation payments shall be made in accordance with the following schedule of capitation payment rates:

For the period 10/01/01 – 9/30/02		**Riverside**
Groups	**Aid Codes**	**Rate**
Family	01, 0A, 02, 08, 30, 32, 33, 34, 35, 38, 39, 40, 42, 47, 54, 59, 72, 3A, 3C, 3E, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 3W, 4F, 4G, 4M, 5X, 7X, 8P	
Disabled	20, 24, 26, 28, 36, 60, 64, 66, 68, 6A, 6C, 6E, 6H, 6J, 6N, 6P, 6R, 6V, 2E, 0M, 0N,0P, 0R, 0T, 0U	
Aged	10,14,16, 18, 1E, 1H	
Child	03, 04, 45, 82, 4A, 4C, 4K, 5K, 7A, 7J, 8R	—
Adult	86	
AIDS Beneficiary		

For the period 10/01/01 – 9/30/02		**San Bernardino**
Groups	**Aid Codes**	**Rate**
Family	01, 0A, 02, 08, 30, 32, 33, 34, 35, 38, 39, 40, 42, 47, 54, 59, 72, 3A, 3C, 3E, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 3W, 4F, 4G, 4M, 5X, 7X, 8P	—
Disabled	20, 24, 26, 28, 36, 60, 64, 66, 68, 6A, 6C, 6E, 6H, 6J, 6N, 6P, 6R, 6V, 2E, 0M, 0N, 0P,0R, 0T, 0U	
Aged	10, 14, 16, 18, 1E, 1H	
Child	03, 04, 45, 82, 4A, 4C, 4K, 5K, 7A, 7J, 8R	
Adult	86	
AIDS Beneficiary		

Exhibit B
Budget Detail and Payment Provisions

For the period 10/01/02 – 7/31/03		**Riverside**
Groups	**Aid Codes**	**Rate**
Family	01, 0A, 02, 08, 30, 32, 33, 34, 35, 38, 39, 40, 42, 47, 54, 59, 72, 3A, 3C, 3E, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 3W, 4F, 4G, 4M, 5X, 7X, 8P	
Disabled	20, 24, 26, 28, 36, 60, 64, 66, 68, 6A, 6C, 6E, 6H, 6J, 6N, 6P, 6R, 6V, 2E, 0M, 0N, 0P, 0R, 0T, 0U	
Aged	10, 14, 16,18, 1E, 1H	
Child	03, 04, 45, 82, 4A, 4C, 4K, 5K, 7A, 7J, 8R	
Adult	86	
AIDS Beneficiary		

For the period 10/01/02 – 7/31/03		**San Bernardino**
Groups	**Aid Codes**	**Rate**
Family	01, 0A, 02, 08, 30, 32, 33, 34, 35, 38, 39, 40, 42, 47, 54, 59, 72, 3A, 3C, 3E, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 3W, 4F, 4G, 4M, 5X, 7X, 8P	
Disabled	20, 24, 26, 28, 36, 60, 64, 66, 68, 6A, 6C, 6E, 6H, 6J, 6N, 6P, 6R, 6V, 2E, 0M, 0N, 0P, 0R, 0T, 0U	
Aged	10, 14, 16, 18, 1E, 1H	
Child	03, 04, 45, 82, 4A, 4C, 4K, 5K, 7A, 7J, 8R	
Adult	86	
AIDS Beneficiary		

Exhibit B
Budget Detail and Payment Provisions

For the period 8/1/03 – 9/30/03		**Riverside**
Groups	**Aid Codes**	**Rate**
Family	01, 0A, 02, 08, 30, 32, 33, 34, 35, 38, 39, 40, 42, 47, 54, 59, 72, 3A, 3C, 3E, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 3W, 4F, 4G, 4M, 5X, 7X, 8P	
Disabled	20, 24, 26, 28, 36, 60, 64, 66, 68, 6A, 6C, 6E, 6H, 6J, 6N, 6P, 6R, 6V, 2E, 0M, 0N, 0P, 0R, 0T, 0U	
Aged	10, 14, 16, 18, 1E, 1H	
Child	03, 04, 45, 82, 4A, 4C, 4K, 5K, 7A, 7J, 8R	
Adult	86	
AIDS Beneficiary		

For the period 8/1/03 – 9/30/03		**San Bernardino**
Groups	**Aid Codes**	**Rate**
Family	01, 0A, 02, 08, 30, 32, 33, 34, 35, 38, 39, 40, 42, 47, 54, 59, 72, 3A, 3C, 3E, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 3W, 4F, 4G, 4M, 5X, 7X, 8P	
Disabled	20, 24, 26, 28, 36, 60, 64, 66, 68, 6A, 6C, 6E, 6H, 6J, 6N, 6P, 6R, 6V, 2E, 0M, 0N, 0P, 0R, 0T, 0U	
Aged	10, 14, 16, 18, 1E, 1H	
Child	03, 04, 45, 82, 4A, 4C, 4K, 5K, 7A, 7J, 8R	
Adult	86	
AIDS Beneficiary		

B. If DHS creates a new aid code that is split or derived from an existing aid code covered under this Contract, and the aid code has a neutral revenue effect for the Contractor, then the split aid code will automatically be included in the same aid code rate group as the original aid code covered

under this Contract. Contractor agrees to continue providing covered services to the Members at the monthly capitation rate specified for the original aid code. DHS shall confirm all aid code splits, and the rates of payment for such new aid codes, in writing to Contractor as soon as practicable after such aid code splits occur.

C. Effective February 1, 2002, an Eligible Beneficiary may continue to be a Member after any redetermination of Medi-Cal eligibility that results in a finding that the individual is eligible for and enrolls under the Breast and Cervical Cancer Treatment Program in order to assure continuity of care. The Breast and Cervical Cancer Treatment Program aid codes are as follows: 0M, 0N, 0P, 0R, 0T, 0U.

Effective February 1, 2002, the BCCTP Aid Group will be added to the Contract and paid at an interim rate equai to the capitation rate negotiated for the Disabled Aid Group. This rate of payment shall continue as an interim payment pursuant to provision 6. Determination of Rates until such time as the Contract is amended to include final capitation rates negotiated specifically for the BCCTP Aid Group. If the final capitation rates proposed by the State are higher or lower than the capitation rate for the Disabled Aid Group, then the capitation rate for the Disabled Aid Group shall be used in determining any adjustments to interim payments pursuant to provision 6. Determination of Rates. Upon approval of the amendment providing for the rate change, the State will make adjustments for the months in which the interim payments were made pursuant to the provisions of provision 6. Determination of Rates.

D. The basis for the determination of the capitation payment rates is outlined in Exhibit B, Attachment 1 (consisting of 24 pages).

5. Capitation Rates Constitute Payment In Full

Capitation rates for each rate period, as calculated by DHS, are prospective rates and constitute payment in full, subject to any stop loss reinsurance provisions, on behalf of a Member for all Covered Services required by such Member and for all Administrative Costs incurred by the Contractor in providing or arranging for such services. DHS is not responsible for making payments for recoupment of losses.

6. Determination Of Rates

A. DHS shall determine the capitation rates for the initial period December 1, 1995, or the Contract effective date of operations, through September 30, 1997. Subsequent to September 30, 1997 and through the duration of the Contract, DHS shall make an annual redetermination of rates in accordance with Title 22, CCR, Section 53869 for each rate year defined

as the 12-month period from October 1, through September 30. DHS reserves the right to establish or negotiate rates on an actuarial basis or move to a negotiated rate for each rate year. All payments and rate adjustments are subject to appropriations of funds by the Legislature and the Department of Finance approval. Further, all payments are subject to the availability of Federal congressional appropriation of funds.

B. If DHS establishes rates on an actuarial basis, it shall determine whether the rates shall be increased, decreased, or remain the same. If it is determined by DHS that Contractor's capitation rates shall be increased or decreased, increase or decrease shall be effectuated through a change order to this Contract in accordance with the provisions of Exhibit E, Attachment 2, provision 4, regarding Change Requirements, subject to the following provisions:

1) The change order shall be effective as of October 1 of each year covered by this Contract.

2) In the event there is any delay in a determination to increase or decrease capitation rates, so that a change order may not be processed in time to permit payment of new rates commencing October 1, the payment to Contractor shall continue at the rates then in effect. Those continued payments shall constitute interim payment only. Upon final approval of the change order providing for the rate change, DHS shall make retroactive adjustments for those months for which interim payment was made.

3) By accepting payment of new annual rates prior to full approval by all control agencies of the change order to this Contract implementing such new rates, Contractor stipulates to a confession of judgment for any amounts received in excess of the final approved rate. If the final approved rate differs from the rates agreed upon by Contractor and DHS:

   a) Any underpayment by the State shall be paid to Contractor within 30 days after final approval of the new rates.

   b) Any overpayment to Contractor shall be recaptured by the State's withholding the amount due from Contractor's next capitation check. If the amount to be withheld from that capitation check exceeds 25 percent of the capitation payment for that month, amounts up to 25 percent shall be withheld from successive capitation payments until the overpayment is fully recovered by the State.

4) If mutual agreement between DHS and Contractor cannot be attained on capitation rates for rate years subsequent to September 30, 1997 resulting from a rate change pursuant to this provision 6 or provision 7 below, Contractor shall retain the right to terminate the Contract, but no earlier than September 30, 1998. Notification of intent to terminate a Contract shall be in writing and provided to DHS at least nine months prior to the effective date of termination, subject to any earlier termination date negotiated in accordance with Exhibit E, Attachment 2, provision 14, regarding Termination - Contractor. DHS shall pay the capitation rates last offered for that rate period until the Contract is terminated.

5) DHS shall make every effort to notify and consult with Contractor regarding proposed redetermination of rates pursuant to this section or provision 7, below at the earliest possible time prior to implementation of the new rate.

7. Redetermination Of Rates - Obligation Changes

The capitation rates may be adjusted during the rate year to provide for a change in obligations that results in an increase or decrease of more than one percent of cost (as defined in Title 22, CCR, Section 53869) to the Contractor. Any adjustments shall be effectuated through a change order to the Contract subject to the following provisions:

A. The change order shall be effective as of the first day of the month in which the change in obligations is effective, as determined by DHS.

B. In the event DHS is unable to process the change order in time to permit payment of the adjusted rates as of the month in which the change in obligations is effective, payment to Contractor shall continue at the rates then in effect. Continued payment shall constitute interim payment only. Upon final approval of the change order providing for the change in obligations, DHS shall make adjustments for those months for which interim payment was made.

C. DHS and Contractor may negotiate an earlier termination date, pursuant to Exhibit E, Attachment 2, provision 14, regarding Termination - Contractor, if a change in contractual obligations is created by a State or Federal change in the Medi-Cal program, or a lawsuit, that substantially alters the financial assumptions and conditions under which Contractor entered into this Contract, such that Contractor can demonstrate to the satisfaction of DHS that it cannot remain financially solvent until the termination date that would otherwise be established under this provision.

Exhibit B
Budget Detail and Payment Provisions

8. Reinsurance

A. Contractor may obtain reinsurance (stop loss coverage) through DHS or other insurers to ensure maintenance of adequate capital by Contractor for the cost of providing Covered Services under this Contract. Reinsurance will not limit the Contractor's liability below $5,000 per Member for any 12-month period as specified by DHS. The Contractor may obtain reinsurance for both of the factors described in Title 22, CCR, Section 53252 (a)(2)(A) & (B).

B. If Contractor selects State reinsurance, Contractor will submit a reinsurance claim form along with copies of the actual claims upon exceeding the reinsurance threshold. As part of the processing, actual claims are priced to appropriate Medi-Cal rates and the appropriate amount in excess of the reinsurance threshold is remitted to the Contractor by DHS.

1) Claims submitted will not be paid by DHS unless received by DHS not later than the last day of the sixth month following the end of the 12-month contract period in which they were incurred.

2) The time specified for submission of claims may be extended for a period not to exceed one year upon a finding of "good cause" by the Director in the following circumstances:

a) Where the claim involves health coverage, other than Medi-Cal, and the delay is necessary to permit the Contractor to obtain payment, partial payment, or proof of non-liability of that other health coverage.

b) Where the claim submission was delayed due to eligibility certification or determination by the State or county.

c) Where there was substantial interference with claim submission due to damage to, or destruction of, the Contractor's (or subcontractor's) business office or records by a natural disaster, including fire, flood or earthquake, or other similar circumstances.

d) Where delay in claims submission was due to other circumstances that are clearly beyond the control of the Contractor. Circumstances that will not be considered beyond the control of the Contractor include, but are not limited to:

i. Negligence or delay of the Contractor or Contractor's employees, agents, and subcontractors.

ii. Misunderstanding of or unfamiliarity with Medi-Cal regulations, or the terms of this Contract.

iii. Illness, absence or other incapacity of a Contractor's employee, agent, or subcontractor responsible for preparation and submission of claims.

iv. Delays caused by the United States Postal Service or any private delivery service.

9. Catastrophic Coverage Limitation

DHS may limit the Contractor's liability to provide or arrange and pay for care for illness of, or injury to Members, which results from or is greatly aggravated by, a catastrophic occurrence or disaster. Contractor will return a prorated amount of the capitation payment following the DHS Director's invocation of the catastrophic coverage limitation. The amount returned will be determined by dividing the total capitation payment by the number of days in the month. The amount will be returned to DHS for each day in the month after the Director has invoked the catastrophic coverage limitation clause.

10. Financial Performance Guarantee

Contractor shall provide satisfactory evidence of, and maintain Financial Performance Guarantee in, an amount equal to at least one month's capitation payment, in a manner specified by DHS. At the Contractor's request, and with DHS approval, Contractor may establish a phase-in schedule to accumulate the required Financial Performance Guarantee. Contractor may elect to satisfy the Financial Performance Guarantee requirement by receiving payment on a post payment basis. The Financial Performance Guarantee shall remain in effect for a period not exceeding 90 days following termination or expiration of this Contract unless DHS has a financial claim against Contractor. Further rights and obligations of the Contractor and the Department, in regards to the Financial Performance Guarantee, shall be as specified in Title 22, CCR, Section 53865.

11. Recovery Of Capitation Payments

DHS shall have the right to recover from Contractor amounts paid to Contractor in the following circumstances as specified:

A. If DHS determines that a Member has either been improperly enrolled due to ineligibility of the Member to enroll in Contractor's plan, residence

outside of Contractor's Service Area, or pursuant to Title 22, Section 53891 (a)(2), or should have been disenrolled with an effective date in a prior month, DHS may recover or, upon request by Contractor, DHS shall recover the capitation payments made to Contractor for the Member and absolve Contractor from all financial and other risk for the provision of services to the Member under the terms of the Contract for the month(s) in question. In such event, Contractor may seek to recover any payments made to providers for Covered Services rendered for the month(s) in question. Contractor shall inform providers that claims for services provided to Members during the month(s) in question shall be paid by DHS' fiscal intermediary, if the Member is determined eligible for the Medi-Cal program.

Upon request by Contractor, DHS may allow Contractor to retain the capitation payments made for Members that are eligible to enroll in Contractor's plan, but should have been retroactively disenrolled pursuant to Exhibit A, Attachment 11, provision 17, regarding Excluded Services Requiring Member Disenrollment, or under other circumstances as approved by DHS. If Contractor retains the capitation payments, Contractor shall provide or arrange and pay for all Medically Necessary Covered Services for the Member, until the Member is disenrolled on a nonretroactive basis pursuant to Exhibit A, Attachment 16, provision 3, regarding Disenrollment.

B. As a result of Contractor's failure to perform contractual responsibilities to comply with mandatory federal Medicaid requirements, the Federal Department of Health and Human Services (DHHS) may disallow Federal Financial Participation (FFP) for payments made by DHS to Contractor. DHS may recover the amounts disallowed by DHHS by an offset to the capitation payments made to Contractor. If recovery of the full amount at one time imposes a financial hardship on Contractor, DHS at its discretion may grant a Contractor's request to repay the recoverable amounts in monthly installments over a period of consecutive months not to exceed six months.

C. If DHS determines that any other erroneous or improper payment not mentioned above has been made to Contractor, DHS may recover the amounts determined by an offset to the capitation payments made to Contractor. If recovery of the full amount at one time imposes a financial hardship on Contractor, DHS, at its discretion, may grant a Contractor's request to repay the recoverable amounts in monthly installments over a period of consecutive months not to exceed six months. At least 30 days prior to seeking any such recovery, DHS shall notify Contractor to explain the improper or erroneous nature of the payment and to describe the recovery process.

Exhibit B
Budget Detail and Payment Provisions

12. Payment Of AIDS Beneficiary Rate

A. Compensation at the AIDS Beneficiary Rate (ABR)

Subject to Contractor's compliance with the requirements contained in subparagraph 1. below, Contractor shall be eligible to receive compensation at the ABR for AIDS Beneficiaries. Compensation to Contractor at the ABR for each AIDS Beneficiary shall consist of payment at the ABR less the capitation rate initially paid for the AIDS beneficiary.

1) Compensation at the ABR shall be subject to the conditions listed below. Contractor's failure to comply with any of the conditions listed below for any request for compensation at the ABR on behalf of an individual AIDS Beneficiary for a specific month of Enrollment shall result in DHS' denial of Contractor's claim for compensation at the ABR for that individual AIDS Beneficiary for that specific month of Enrollment. Contractor may submit a corrected claim, within the timeframes specified in paragraph d below, that complies with all the conditions listed below and DHS shall reimburse Contractor at the ABR.

a) The ABR shall be in lieu of any other compensation for an AIDS Beneficiary in any month.

b) For AIDS Beneficiaries, Contractor shall be eligible to receive compensation at the ABR commencing in the month in which a Diagnosis of AIDS is made and recorded, dated and signed by the treating physician in the AIDS Beneficiary's Medical Record.

c) Contractor shall submit an invoice to DHS by the 25th day of each month for claims for compensation at the ABR for AIDS Beneficiaries. The invoice shall include the following:

i. A list of all AIDS Beneficiaries identified by Medi-Cal numbers only for whom the Contractor is claiming compensation at the ABR. Member names shall not be used.

ii. The month(s) and year(s) for which compensation at the ABR is being claimed for each AIDS Beneficiary listed, sorted by month and year of service.

Exhibit B
Budget Detail and Payment Provisions

iii. The capitation rate initially paid for the AIDS Beneficiary for each month being claimed by the Contractor, the ABR being claimed, and the difference between the ABR and the capitation rate initially paid for the AIDS Beneficiary.

iv. The total amount being claimed on the invoice.

d) Invoices, containing originally submitted claims or corrected claims, for compensation at the ABR for any month of eligibility during the rate year beginning October 1, 1997, and ending September 30, 1998, or any rate year thereafter beginning October 1 and ending September 30, must be submitted by Contractor to DHS no later than six months following the end of the subject rate year.

e) Invoices shall include the Agreement Number and shall be submitted to:

Department of Health Services
Medi-Cal Managed Care Division
Attn: Fiscal Analysis Unit
Mailing Address: See Exhibit A, Scope of Work

In addition, invoices shall:

i. Be prepared on company letterhead.

ii. Bear the Contractor's name as shown on the agreement.

iii. Be signed by an authorized official, employee or agent.

2) Contractor shall confirm Medi-Cal eligibility of AIDS Beneficiaries prior to submission of the monthly invoice to DHS. DHS may verify the Medi-Cal eligibility of each Member for whom the ABR is claimed and adjust the invoiced amounts to reflect any capitation payments that have been previously made to Contractor for each Member prior to submission of the invoice required under paragraph 1.c above.

3) If DHS determines that a Member for whom compensation has been paid at the ABR did not meet the definition of an AIDS Beneficiary, in a month for which the ABR was paid, DHS shall recover any amount improperly paid, by an offset to Contractor's capitation payment, in accordance with provision 11. Recovery of Capitation Payments, paragraph C. DHS shall give Contractor 30 days prior written notice of any such offset.

Exhibit B
Budget Detail and Payment Provisions

B. Prompt Payment Clause

Payment will be made in accordance with, and within the time specified in, Chapter 4.5 (commencing with Section 927), Part 3, Division 3.6, of Title 2 of the Government Code.

C. Timely Submission of Final Invoice

1) A final undisputed ABR invoice shall be submitted for payment no more than ninety (90) calendar days following the expiration or termination date of this agreement, unless a later or alternate deadline is agreed to in writing by the program contract manager. Said ABR invoice should be clearly marked "Final Invoice - ABR", thus indicating that all payment obligations of the State under this agreement have ceased and that no further payments are due or outstanding.

2) The State may, at its discretion, choose not to honor any delinquent final ABR invoice if the Contractor fails to obtain prior written State approval of an alternate final ABR invoice submission deadline. Written State approval shall be sought from the program contract manager prior to the expiration or termination date of this agreement.

3) The Contractor is hereby advised of its obligation to submit, with the final ABR invoice, a "Contractor's Release (Exhibit F)" acknowledging submission of the final ABR invoice to the State and certifying the approximate percentage amount, if any, of recycled products used in performance of this agreement.

Plan Name:	Molina Medical Center	Plan #: 355	Date: 22-Sep-03
County:	Riverside	Plan Type: Commercial Plan	
Aid Code Grouping:	Family		

The Rate Period is October 1, 2002 to September 30, 2003

Capitation Payments at the End of the Month

Coverages (C = Covered by Plan, N = NOT Covered by Plan)

CCS Indicated Claims	N	Newborn Hearing Screening	N
GHPP	N	MH - Hospital Inpatient	N
Hemodialysis	C	MH - Outpatient Services	N
Major Organ Transplant	N	MH - Psychotropic Drugs	N
Chiropractor	N	Psychiatrist	N
Acupuncturist	N	LTC Month of Entry Plus 1	C
Lenses for Eyeware	N	LTC After Month of Entry Plus 1	N
Local Education Authority	N	Targeted Case Management	N
Alphafeto Protein Testing	N	Short-Doyle Mental Health	N
Direct Observed Therapy	N	Multipurpose Senior Support Program	N
Heroin Detoxification	N	Services at State or Federal Hospitals	N
AIDS Waiver	N	Out of State Services	C
Special AIDS Drugs	N	Childhood Lead Screening	C
In Home Waiver	N	CHDP Services	C
Model NF Waiver	N	Home/Community Based Services	N
Adult Day Health Care	N		

	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	Total
Rate Calculation							
1. Average Cost Per Unit							
2. Units per Eligible/year							
Cost per Elig. per Mo.							
3. Adjustments							
a. Age/Sex							
b. Area							
c. Coverages							
d. Interest							
Adjusted Base Cost							
4. Legislative Adjustments							
5. Trend Adjustments							
Projected Cost per Eligible							
6. Adjustment to Pool							
Capitation Rate							

Prepared by Department of Health Services, Rate Development Branch

Plan Name:	Molina Medical Center	Plan #: 355	Date: 22-Sep-03
County:	Riverside	Plan Type: Commercial Plan	
Aid Code Grouping:	Disabled		

The Rate Period is October 1, 2002 to September 30, 2003

Capitation Payments at the End of the Month

Coverages (C = Covered by Plan, N = NOT Covered by Plan)

CCS Indicated Claims	N	Newborn Hearing Screening	N
GHPP	N	MH - Hospital Inpatient	N
Hemodialysis	C	MH - Outpatient Services	N
Major Organ Transplant	N	MH - Psychotropic Drugs	N
Chiropractor	N	Psychiatrist	N
Acupuncturist	N	LTC Month of Entry Plus 1	C
Lenses for Eyeware	N	LTC After Month of Entry Plus 1	N
Local Education Authority	N	Targeted Case Management	N
Alphafeto Protein Testing	N	Short-Doyle Mental Health	N
Direct Observed Therapy	N	Multipurpose Senior Support Program	N
Heroin Detoxification	N	Services at State or Federal Hospitals	N
AIDS Waiver	N	Out of State Services	C
Special AIDS Drugs	N	Childhood Lead Screening	C
In Home Waiver	N	CHDP Services	C
Model NF Waiver	N	Home/Community Based Services	N
Adult Day Health Care	N		

	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	Total
Rate Calculation							
1. Average Cost Per Unit							
2. Units per Eligible/year							
Cost per Elig. per Mo.							
3. Adjustments							
a. Age/Sex							
b. Area							
c. Coverages							
d. Interest							
Adjusted Base Cost							
4. Legislative Adjustments							
5. Trend Adjustments							
Projected Cost per Eligible							
6. Adjustment to Pool							
Capitation Rate							

Prepared by Department of Health Services, Rate Development Branch

Plan Name:	Molina Medical Center	Plan #: 355	Date: 22-Sep-03
County:	Riverside	Plan Type: Commercial Plan	
Aid Code Grouping:	Aged		

The Rate Period is October 1, 2002 to September 30, 2003

Capitation Payments at the End of the Month

Coverages (C = Covered by Plan, N = NOT Covered by Plan)

CCS Indicated Claims	N	Newborn Hearing Screening	N
GHPP	N	MH - Hospital Inpatient	N
Hemodialysis	C	MH - Outpatient Services	N
Major Organ Transplant	N	MH - Psychotropic Drugs	N
Chiropractor	N	Psychiatrist	N
Acupuncturist	N	LTC Month of Entry Plus 1	C
Lenses for Eyeware	N	LTC After Month of Entry Plus 1	N
Local Education Authority	N	Targeted Case Management	N
Alphafeto Protein Testing	N	Short-Doyle Mental Health	N
Direct Observed Therapy	N	Multipurpose Senior Support Program	N
Heroin Detoxification	N	Services at State or Federal Hospitals	N
AIDS Waiver	N	Out of State Services	C
Special AIDS Drugs	N	Childhood Lead Screening	C
In Home Waiver	N	CHDP Services	C
Model NF Waiver	N	Home/Community Based Services	N
Adult Day Health Care	N		

	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	Total
Rate Calculation							
1. Average Cost Per Unit							
2. Units per Eligible/year							
Cost per Elig. per Mo.							
3. Adjustments							
a. Age/Sex							
b. Area							
c. Coverages							
d. Interest							
Adjusted Base Cost							
4. Legislative Adjustments							
5. Trend Adjustments							
Projected Cost per Eligible							
6. Adjustment to Pool							
Capitation Rate							

Prepared by Department of Health Services, Rate Development Branch

Plan Name:	Molina Medical Center	Plan #: 355	Date: 22-Sep-03
County:	Riverside	Plan Type: Commercial Plan	
Aid Code Grouping:	Child		

The Rate Period is October 1, 2002 to September 30, 2003

Capitation Payments at the End of the Month

Coverages (C = Covered by Plan, N = NOT Covered by Plan)

CCS Indicated Claims	N	Newborn Hearing Screening	N
GHPP	N	MH - Hospital Inpatient	N
Hemodialysis	C	MH - Outpatient Services	N
Major Organ Transplant	N	MH - Psychotropic Drugs	N
Chiropractor	N	Psychiatrist	N
Acupuncturist	N	LTC Month of Entry Plus 1	C
Lenses for Eyeware	N	LTC After Month of Entry Plus 1	N
Local Education Authority	N	Targeted Case Management	N
Alphafeto Protein Testing	N	Short-Doyle Mental Health	N
Direct Observed Therapy	N	Multipurpose Senior Support Program	N
Heroin Detoxification	N	Services at State or Federal Hospitals	N
AIDS Waiver	N	Out of State Services	C
Special AIDS Drugs	N	Childhood Lead Screening	C
In Home Waiver	N	CHDP Services	C
Model NF Waiver	N	Home/Community Based Services	N
Adult Day Health Care	N		

	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	Total
Rate Calculation							
1. Average Cost Per Unit							
2. Units per Eligible/year							
Cost per Elig. per Mo.							
3. Adjustments							
a. Age/Sex							
b. Area							
c. Coverages							
d. Interest							
Adjusted Base Cost							
4. Legislative Adjustments							
5. Trend Adjustments							
Projected Cost per Eligible							
6. Adjustment to Pool							
Capitation Rate							

Prepared by Department of Health Services, Rate Development Branch

Plan Name:	Molina Medical Center	Plan #: 355	Date: 22-Sep-03
County:	Riverside	Plan Type: Commercial Plan	
Aid Code Grouping:	Adult		

The Rate Period is October 1, 2002 to September 30, 2003

Capitation Payments at the End of the Month

Coverages (C = Covered by Plan, N = NOT Covered by Plan)

CCS Indicated Claims	N	Newborn Hearing Screening	N
GHPP	N	MH - Hospital Inpatient	N
Hemodialysis	C	MH - Outpatient Services	N
Major Organ Transplant	N	MH - Psychotropic Drugs	N
Chiropractor	N	Psychiatrist	N
Acupuncturist	N	LTC Month of Entry Plus 1	C
Lenses for Eyeware	N	LTC After Month of Entry Plus 1	N
Local Education Authority	N	Targeted Case Management	N
Alphafeto Protein Testing	N	Short-Doyle Mental Health	N
Direct Observed Therapy	N	Multipurpose Senior Support Program	N
Heroin Detoxification	N	Services at State or Federal Hospitals	N
AIDS Waiver	N	Out of State Services	C
Special AIDS Drugs	N	Childhood Lead Screening	C
In Home Waiver	N	CHDP Services	C
Model NF Waiver	N	Home/Community Based Services	N
Adult Day Health Care	N		

	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	Total
Rate Calculation							
1. Average Cost Per Unit							
2. Units per Eligible/year							
Cost per Elig. per Mo.							
3. Adjustments							
a. Age/Sex							
b. Area							
c. Coverages							
d. Interest							
Adjusted Base Cost							
4. Legislative Adjustments							
5. Trend Adjustments							
Projected Cost per Eligible							
6. Adjustment to Pool							
Capitation Rate							

Prepared by Department of Health Services, Rate Development Branch

Plan Name:	Molina Medical Center	Plan #: 355	Date: 22-Sep-03
County:	Riverside	Plan Type: Commercial Plan	
Aid Code Grouping:	AIDS		

The Rate Period is October 1, 2002 to September 30, 2003

Capitation Payments at the End of the Month

Coverages (C = Covered by Plan, N = NOT Covered by Plan)

CCS Indicated Claims	N	Newborn Hearing Screening	N
GHPP	N	MH - Hospital Inpatient	N
Hemodialysis	C	MH - Outpatient Services	N
Major Organ Transplant	N	MH - Psychotropic Drugs	N
Chiropractor	N	Psychiatrist	N
Acupuncturist	N	LTC Month of Entry Plus 1	C
Lenses for Eyeware	N	LTC After Month of Entry Plus 1	N
Local Education Authority	N	Targeted Case Management	N
Alphafeto Protein Testing	N	Short-Doyle Mental Health	N
Direct Observed Therapy	N	Multipurpose Senior Support Program	N
Heroin Detoxification	N	Services at State or Federal Hospitals	N
AIDS Waiver	N	Out of State Services	C
Special AIDS Drugs	N	Childhood Lead Screening	C
In Home Waiver	N	CHDP Services	C
Model NF Waiver	N	Home/Community Based Services	N
Adult Day Health Care	N		

	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	Total
Rate Calculation							
1. Average Cost Per Unit							
2. Units per Eligible/year							
Cost per Elig. per Mo.							
3. Adjustments							
a. Age/Sex							
b. Area							
c. Coverages							
d. Interest							
Adjusted Base Cost							
4. Legislative Adjustments							
5. Trend Adjustments							
Projected Cost per Eligible							
6. Adjustment to Pool							
Capitation Rate							

Prepared by Department of Health Services, Rate Development Branch

Plan Name:	Molina Medical Center	Plan #: 356	Date: 22-Sep-03
County:	San Bernardino	Plan Type: Commercial Plan	
Aid Code Grouping:	Family		

The Rate Period is October 1, 2002 to September 30, 2003

Capitation Payments at the End of the Month

Coverages (C = Covered by Plan, N = NOT Covered by Plan)

CCS Indicated Claims	N	Newborn Hearing Screening	N
GHPP	N	MH - Hospital Inpatient	N
Hemodialysis	C	MH - Outpatient Services	N
Major Organ Transplant	N	MH - Psychotropic Drugs	N
Chiropractor	N	Psychiatrist	N
Acupuncturist	N	LTC Month of Entry Plus 1	C
Lenses for Eyeware	N	LTC After Month of Entry Plus 1	N
Local Education Authority	N	Targeted Case Management	N
Alphafeto Protein Testing	N	Short-Doyle Mental Health	N
Direct Observed Therapy	N	Multipurpose Senior Support Program	N
Heroin Detoxification	N	Services at State or Federal Hospitals	N
AIDS Waiver	N	Out of State Services	C
Special AIDS Drugs	N	Childhood Lead Screening	C
In Home Waiver	N	CHDP Services	C
Model NF Waiver	N	Home/Community Based Services	N
Adult Day Health Care	N		

	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	Total
Rate Calculation							
1. Average Cost Per Unit							
2. Units per Eligible/year							
Cost per Elig. per Mo.							
3. Adjustments							
a. Age/Sex							
b. Area							
c. Coverages							
d. Interest							
Adjusted Base Cost							
4. Legislative Adjustments							
5. Trend Adjustments							
Projected Cost per Eligible							
6. Adjustment to Pool							
Capitation Rate							

Prepared by Department of Health Services, Rate Development Branch

Plan Name:	Molina Medical Center	Plan #: 356	Date: 22-Sep-03
County:	San Bernardino	Plan Type: Commercial Plan	
Aid Code Grouping:	Disabled		

The Rate Period is October 1, 2002 to September 30, 2003

Capitation Payments at the End of the Month

Coverages (C = Covered by Plan, N = NOT Covered by Plan)

CCS Indicated Claims	N	Newborn Hearing Screening	N
GHPP	N	MH - Hospital Inpatient	N
Hemodialysis	C	MH - Outpatient Services	N
Major Organ Transplant	N	MH - Psychotropic Drugs	N
Chiropractor	N	Psychiatrist	N
Acupuncturist	N	LTC Month of Entry Plus 1	C
Lenses for Eyeware	N	LTC After Month of Entry Plus 1	N
Local Education Authority	N	Targeted Case Management	N
Alphafeto Protein Testing	N	Short-Doyle Mental Health	N
Direct Observed Therapy	N	Multipurpose Senior Support Program	N
Heroin Detoxification	N	Services at State or Federal Hospitals	N
AIDS Waiver	N	Out of State Services	C
Special AIDS Drugs	N	Childhood Lead Screening	C
In Home Waiver	N	CHDP Services	C
Model NF Waiver	N	Home/Community Based Services	N
Adult Day Health Care	N		

	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	Total
Rate Calculation							
1. Average Cost Per Unit							
2. Units per Eligible/year							
Cost per Elig. per Mo.							
3. Adjustments							
a. Age/Sex							
b. Area							
c. Coverages							
d. Interest							
Adjusted Base Cost							
4. Legislative Adjustments							
5. Trend Adjustments							
Projected Cost per Eligible							
6. Adjustment to Pool							
Capitation Rate							

Prepared by Department of Health Services, Rate Development Branch

Plan Name:	Molina Medical Center	Plan #: 356	Date: 22-Sep-03
County:	San Bernardino	Plan Type: Commercial Plan	
Aid Code Grouping:	Aged		

The Rate Period is October 1, 2002 to September 30, 2003

Capitation Payments at the End of the Month

Coverages (C = Covered by Plan, N = NOT Covered by Plan)

CCS Indicated Claims	N	Newborn Hearing Screening	N
GHPP	N	MH - Hospital Inpatient	N
Hemodialysis	C	MH - Outpatient Services	N
Major Organ Transplant	N	MH - Psychotropic Drugs	N
Chiropractor	N	Psychiatrist	N
Acupuncturist	N	LTC Month of Entry Plus 1	C
Lenses for Eyeware	N	LTC After Month of Entry Plus 1	N
Local Education Authority	N	Targeted Case Management	N
Alphafeto Protein Testing	N	Short-Doyle Mental Health	N
Direct Observed Therapy	N	Multipurpose Senior Support Program	N
Heroin Detoxification	N	Services at State or Federal Hospitals	N
AIDS Waiver	N	Out of State Services	C
Special AIDS Drugs	N	Childhood Lead Screening	C
In Home Waiver	N	CHDP Services	C
Model NF Waiver	N	Home/Community Based Services	N
Adult Day Health Care	N		

	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	Total
Rate Calculation							
1. Average Cost Per Unit							
2. Units per Eligible/year							
Cost per Elig. per Mo.							
3. Adjustments							
a. Age/Sex							
b. Area							
c. Coverages							
d. Interest							
Adjusted Base Cost							
4. Legislative Adjustments							
5. Trend Adjustments							
Projected Cost per Eligible							
6. Adjustment to Pool							
Capitation Rate							

Prepared by Department of Health Services, Rate Development Branch

Plan Name:	Molina Medical Center	Plan #: 356	Date: 22-Sep-03
County:	San Bernardino	Plan Type: Commercial Plan	
Aid Code Grouping:	Child		

The Rate Period is October 1, 2002 to September 30, 2003

Capitation Payments at the End of the Month

Coverages (C = Covered by Plan, N = NOT Covered by Plan)

CCS Indicated Claims	N	Newborn Hearing Screening	N
GHPP	N	MH - Hospital Inpatient	N
Hemodialysis	C	MH - Outpatient Services	N
Major Organ Transplant	N	MH - Psychotropic Drugs	N
Chiropractor	N	Psychiatrist	N
Acupuncturist	N	LTC Month of Entry Plus 1	C
Lenses for Eyeware	N	LTC After Month of Entry Plus 1	N
Local Education Authority	N	Targeted Case Management	N
Alphafeto Protein Testing	N	Short-Doyle Mental Health	N
Direct Observed Therapy	N	Multipurpose Senior Support Program	N
Heroin Detoxification	N	Services at State or Federal Hospitals	N
AIDS Waiver	N	Out of State Services	C
Special AIDS Drugs	N	Childhood Lead Screening	C
In Home Waiver	N	CHDP Services	C
Model NF Waiver	N	Home/Community Based Services	N
Adult Day Health Care	N		

	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	Total
Rate Calculation							
1. Average Cost Per Unit							
2. Units per Eligible/year							
Cost per Elig. per Mo.							
3. Adjustments							
a. Age/Sex							
b. Area							
c. Coverages							
d. Interest							
Adjusted Base Cost							
4. Legislative Adjustments							
5. Trend Adjustments							
Projected Cost per Eligible							
6. Adjustment to Pool							
Capitation Rate							

Prepared by Department of Health Services, Rate Development Branch

Plan Name:	Molina Medical Center	Plan #: 356	Date: 22-Sep-03
County:	San Bernardino	Plan Type: Commercial Plan	
Aid Code Grouping:	Adult		

The Rate Period is October 1, 2002 to September 30, 2003

Capitation Payments at the End of the Month

Coverages (C = Covered by Plan, N = NOT Covered by Plan)

CCS Indicated Claims	N	Newborn Hearing Screening	N
GHPP	N	MH - Hospital Inpatient	N
Hemodialysis	C	MH - Outpatient Services	N
Major Organ Transplant	N	MH - Psychotropic Drugs	N
Chiropractor	N	Psychiatrist	N
Acupuncturist	N	LTC Month of Entry Plus 1	C
Lenses for Eyeware	N	LTC After Month of Entry Plus 1	N
Local Education Authority	N	Targeted Case Management	N
Alphafeto Protein Testing	N	Short-Doyle Mental Health	N
Direct Observed Therapy	N	Multipurpose Senior Support Program	N
Heroin Detoxification	N	Services at State or Federal Hospitals	N
AIDS Waiver	N	Out of State Services	C
Special AIDS Drugs	N	Childhood Lead Screening	C
In Home Waiver	N	CHDP Services	C
Model NF Waiver	N	Home/Community Based Services	N
Adult Day Health Care	N		

	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	Total
Rate Calculation							
1. Average Cost Per Unit							
2. Units per Eligible/year							
Cost per Elig. per Mo.							
3. Adjustments							
a. Age/Sex							
b. Area							
c. Coverages							
d. Interest							
Adjusted Base Cost							
4. Legislative Adjustments							
5. Trend Adjustments							
Projected Cost per Eligible							
6. Adjustment to Pool							
Capitation Rate							

Prepared by Department of Health Services, Rate Development Branch

Plan Name:	Molina Medical Center	Plan #:	356	Date: 22-Sep-03
County:	San Bernardino	Plan Type:	Commercial Plan	
Aid Code Grouping:	AIDS			

The Rate Period is October 1, 2002 to September 30, 2003

Capitation Payments at the End of the Month

Coverages (C = Covered by Plan, N = NOT Covered by Plan)

CCS Indicated Claims	N	Newborn Hearing Screening	N
GHPP	N	MH - Hospital Inpatient	N
Hemodialysis	C	MH - Outpatient Services	N
Major Organ Transplant	N	MH - Psychotropic Drugs	N
Chiropractor	N	Psychiatrist	N
Acupuncturist	N	LTC Month of Entry Plus 1	C
Lenses for Eyeware	N	LTC After Month of Entry Plus 1	N
Local Education Authority	N	Targeted Case Management	N
Alphafeto Protein Testing	N	Short-Doyle Mental Health	N
Direct Observed Therapy	N	Multipurpose Senior Support Program	N
Heroin Detoxification	N	Services at State or Federal Hospitals	N
AIDS Waiver	N	Out of State Services	C
Special AIDS Drugs	N	Childhood Lead Screening	C
In Home Waiver	N	CHDP Services	C
Model NF Waiver	N	Home/Community Based Services	N
Adult Day Health Care	N		

	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	Total
Rate Calculation							
1. Average Cost Per Unit							
2. Units per Eligible/year							
Cost per Elig. per Mo.							
3. Adjustments							
a. Age/Sex							
b. Area							
c. Coverages							
d. Interest							
Adjusted Base Cost							
4. Legislative Adjustments							
5. Trend Adjustments							
Projected Cost per Eligible							
6. Adjustment to Pool							
Capitation Rate							

Prepared by Department of Health Services, Rate Development Branch

Plan Name:	Molina Medical Center	Plan #: 355	Date: 22-Sep-03
County:	Riverside	Plan Type: Commercial Plan	
Aid Code Grouping:	Family		

The Rate Period is August 1, 2003 to September 30, 2003

Capitation Payments at the End of the Month

Coverages (C = Covered by Plan, N = NOT Covered by Plan)

CCS Indicated Claims	N	Newborn Hearing Screening	N
GHPP	N	MH - Hospital Inpatient	N
Hemodialysis	C	MH - Outpatient Services	N
Major Organ Transplant	N	MH - Psychotropic Drugs	N
Chiropractor	N	Psychiatrist	N
Acupuncturist	N	LTC Month of Entry Plus 1	C
Lenses for Eyeware	N	LTC After Month of Entry Plus 1	N
Local Education Authority	N	Targeted Case Management	N
Alphafeto Protein Testing	N	Short-Doyle Mental Health	N
Direct Observed Therapy	N	Multipurpose Senior Support Program	N
Heroin Detoxification	N	Services at State or Federal Hospitals	N
AIDS Waiver	N	Out of State Services	C
Special AIDS Drugs	N	Childhood Lead Screening	C
In Home Waiver	N	CHDP Services	C
Model NF Waiver	N	Home/Community Based Services	N
Adult Day Health Care	N	Abortions	N

	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	Total
Rate Calculation							
1. Average Cost Per Unit							
2. Units per Eligible/year							
Cost per Elig. per Mo.							
3. Adjustments							
a. Age/Sex							
b. Area							
c. Coverages							
d. Interest							
Adjusted Base Cost							
4. Legislative Adjustments							
5. Trend Adjustments							
Projected Cost per Eligible							
6. Adjustment to Pool							
Total Capitation Rate							
Adjustment for Abortions							
Net Capitation Rate							

Prepared by Department of Health Services, Rate Development Branch

Plan Name:	Molina Medical Center	Plan #: 355	Date: 22-Sep-03
County:	Riverside	Plan Type: Commercial Plan	
Aid Code Grouping:	Disabled		

The Rate Period is August 1, 2003 to September 30, 2003

Capitation Payments at the End of the Month

Coverages (C = Covered by Plan, N = NOT Covered by Plan)

CCS Indicated Claims	N	Newborn Hearing Screening	N
GHPP	N	MH - Hospital Inpatient	N
Hemodialysis	C	MH - Outpatient Services	N
Major Organ Transplant	N	MH - Psychotropic Drugs	N
Chiropractor	N	Psychiatrist	N
Acupuncturist	N	LTC Month of Entry Plus 1	C
Lenses for Eyeware	N	LTC After Month of Entry Plus 1	N
Local Education Authority	N	Targeted Case Management	N
Alphafeto Protein Testing	N	Short-Doyle Mental Health	N
Direct Observed Therapy	N	Multipurpose Senior Support Program	N
Heroin Detoxification	N	Services at State or Federal Hospitals	N
AIDS Waiver	N	Out of State Services	C
Special AIDS Drugs	N	Childhood Lead Screening	C
In Home Waiver	N	CHDP Services	C
Model NF Waiver	N	Home/Community Based Services	N
Adult Day Health Care	N	Abortions	N

	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	Total
Rate Calculation							
1. Average Cost Per Unit							
2. Units per Eligible/year							
Cost per Elig. per Mo.							
3. Adjustments							
a. Age/Sex							
b. Area							
c. Coverages							
d. Interest							
Adjusted Base Cost							
4. Legislative Adjustments							
5. Trend Adjustments							
Projected Cost per Eligible							
6. Adjustment to Pool							
Total Capitation Rate							
Adjustment for Abortions							
Net Capitation Rate							

Prepared by Department of Health Services, Rate Development Branch

Plan Name:	Molina Medical Center	Plan #: 355	Date: 22-Sep-03
County:	Riverside	Plan Type: Commercial Plan	
Aid Code Grouping:	Aged		

The Rate Period is August 1, 2003 to September 30, 2003

Capitation Payments at the End of the Month

Coverages (C = Covered by Plan, N = NOT Covered by Plan)

CCS Indicated Claims	N	Newborn Hearing Screening	N
GHPP	N	MH - Hospital Inpatient	N
Hemodialysis	C	MH - Outpatient Services	N
Major Organ Transplant	N	MH - Psychotropic Drugs	N
Chiropractor	N	Psychiatrist	N
Acupuncturist	N	LTC Month of Entry Plus 1	C
Lenses for Eyeware	N	LTC After Month of Entry Plus 1	N
Local Education Authority	N	Targeted Case Management	N
Alphafeto Protein Testing	N	Short-Doyle Mental Health	N
Direct Observed Therapy	N	Multipurpose Senior Support Program	N
Heroin Detoxification	N	Services at State or Federal Hospitals	N
AIDS Waiver	N	Out of State Services	C
Special AIDS Drugs	N	Childhood Lead Screening	C
In Home Waiver	N	CHDP Services	C
Model NF Waiver	N	Home/Community Based Services	N
Adult Day Health Care	N	Abortions	N

	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	Total
Rate Calculation							
1. Average Cost Per Unit							
2. Units per Eligible/year							
Cost per Elig. per Mo.							
3. Adjustments							
a. Age/Sex							
b. Area							
c. Coverages							
d. Interest							
Adjusted Base Cost							
4. Legislative Adjustments							
5. Trend Adjustments							
Projected Cost per Eligible							
6. Adjustment to Pool							
Total Capitation Rate							
Adjustment for Abortions							
Net Capitation Rate							

Prepared by Department of Health Services, Rate Development Branch

Plan Name:	Molina Medical Center	Plan #: 355	Date: 22-Sep-03
County:	Riverside	Plan Type: Commercial Plan	
Aid Code Grouping:	Child		

The Rate Period is August 1, 2003 to September 30, 2003

Capitation Payments at the End of the Month

Coverages (C = Covered by Plan, N = NOT Covered by Plan)

CCS Indicated Claims	N	Newborn Hearing Screening	N
GHPP	N	MH - Hospital Inpatient	N
Hemodialysis	C	MH - Outpatient Services	N
Major Organ Transplant	N	MH - Psychotropic Drugs	N
Chiropractor	N	Psychiatrist	N
Acupuncturist	N	LTC Month of Entry Plus 1	C
Lenses for Eyeware	N	LTC After Month of Entry Plus 1	N
Local Education Authority	N	Targeted Case Management	N
Alphafeto Protein Testing	N	Short-Doyle Mental Health	N
Direct Observed Therapy	N	Multipurpose Senior Support Program	N
Heroin Detoxification	N	Services at State or Federal Hospitals	N
AIDS Waiver	N	Out of State Services	C
Special AIDS Drugs	N	Childhood Lead Screening	C
In Home Waiver	N	CHDP Services	C
Model NF Waiver	N	Home/Community Based Services	N
Adult Day Health Care	N	Abortions	N

	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	Total
Rate Calculation							
1. Average Cost Per Unit							
2. Units per Eligible/year							
Cost per Elig. per Mo.							
3. Adjustments							
a. Age/Sex							
b. Area							
c. Coverages							
d. Interest							
Adjusted Base Cost							
4. Legislative Adjustments							
5. Trend Adjustments							
Projected Cost per Eligible							
6. Adjustment to Pool							
Total Capitation Rate							
Adjustment for Abortions							
Net Capitation Rate							

Prepared by Department of Health Services, Rate Development Branch

Plan Name:	Molina Medical Center	Plan #: 355	Date: 22-Sep-03
County:	Riverside	Plan Type: Commercial Plan	
Aid Code Grouping:	Adult		

The Rate Period is August 1, 2003 to September 30, 2003

Capitation Payments at the End of the Month

Coverages (C = Covered by Plan, N = NOT Covered by Plan)

CCS Indicated Claims	N	Newborn Hearing Screening	N
GHPP	N	MH - Hospital Inpatient	N
Hemodialysis	C	MH - Outpatient Services	N
Major Organ Transplant	N	MH - Psychotropic Drugs	N
Chiropractor	N	Psychiatrist	N
Acupuncturist	N	LTC Month of Entry Plus 1	C
Lenses for Eyeware	N	LTC After Month of Entry Plus 1	N
Local Education Authority	N	Targeted Case Management	N
Alphafeto Protein Testing	N	Short-Doyle Mental Health	N
Direct Observed Therapy	N	Multipurpose Senior Support Program	N
Heroin Detoxification	N	Services at State or Federal Hospitals	N
AIDS Waiver	N	Out of State Services	C
Special AIDS Drugs	N	Childhood Lead Screening	C
In Home Waiver	N	CHDP Services	C
Model NF Waiver	N	Home/Community Based Services	N
Adult Day Health Care	N	Abortions	N

	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	Total
Rate Calculation							
1. Average Cost Per Unit							
2. Units per Eligible/year							
Cost per Elig. per Mo.							
3. Adjustments							
a. Age/Sex							
b. Area							
c. Coverages							
d. Interest							
Adjusted Base Cost							
4. Legislative Adjustments							
5. Trend Adjustments							
Projected Cost per Eligible							
6. Adjustment to Pool							
Total Capitation Rate							
Adjustment for Abortions							
Net Capitation Rate							

Prepared by Department of Health Services, Rate Development Branch

Plan Name:	Molina Medical Center	Plan #: 355	Date: 22-Sep-03
County:	Riverside	Plan Type: Commercial Plan	
Aid Code Grouping:	AIDS		

The Rate Period is August 1, 2003 to September 30, 2003

Capitation Payments at the End of the Month

Coverages (C = Covered by Plan, N = NOT Covered by Plan)

CCS Indicated Claims	N	Newborn Hearing Screening	N
GHPP	N	MH - Hospital Inpatient	N
Hemodialysis	C	MH - Outpatient Services	N
Major Organ Transplant	N	MH - Psychotropic Drugs	N
Chiropractor	N	Psychiatrist	N
Acupuncturist	N	LTC Month of Entry Plus 1	C
Lenses for Eyeware	N	LTC After Month of Entry Plus 1	N
Local Education Authority	N	Targeted Case Management	N
Alphafeto Protein Testing	N	Short-Doyle Mental Health	N
Direct Observed Therapy	N	Multipurpose Senior Support Program	N
Heroin Detoxification	N	Services at State or Federal Hospitals	N
AIDS Waiver	N	Out of State Services	C
Special AIDS Drugs	N	Childhood Lead Screening	C
In Home Waiver	N	CHDP Services	C
Model NF Waiver	N	Home/Community Based Services	N
Adult Day Health Care	N	Abortions	N

	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	Total
Rate Calculation							
1. Average Cost Per Unit							
2. Units per Eligible/year							
Cost per Elig. per Mo.							
3. Adjustments							
a. Age/Sex							
b. Area							
c. Coverages							
d. Interest							
Adjusted Base Cost							
4. Legislative Adjustments							
5. Trend Adjustments							
Projected Cost per Eligible							
6. Adjustment to Pool							
Total Capitation Rate							
Adjustment for Abortions							
Net Capitation Rate							

Prepared by Department of Health Services, Rate Development Branch

Plan Name:	Molina Medical Center	Plan #:	356	Date: 22-Sep-03
County:	San Bernardino	Plan Type:	Commercial Plan	
Aid Code Grouping:	Family			

The Rate Period is August 1, 2003 to September 30, 2003

Capitation Payments at the End of the Month

Coverages (C = Covered by Plan, N = NOT Covered by Plan)

CCS Indicated Claims	N	Newborn Hearing Screening	N
GHPP	N	MH - Hospital Inpatient	N
Hemodialysis	C	MH - Outpatient Services	N
Major Organ Transplant	N	MH - Psychotropic Drugs	N
Chiropractor	N	Psychiatrist	N
Acupuncturist	N	LTC Month of Entry Plus 1	C
Lenses for Eyeware	N	LTC After Month of Entry Plus 1	N
Local Education Authority	N	Targeted Case Management	N
Alphafeto Protein Testing	N	Short-Doyle Mental Health	N
Direct Observed Therapy	N	Multipurpose Senior Support Program	N
Heroin Detoxification	N	Services at State or Federal Hospitals	N
AIDS Waiver	N	Out of State Services	C
Special AIDS Drugs	N	Childhood Lead Screening	C
In Home Waiver	N	CHDP Services	C
Model NF Waiver	N	Home/Community Based Services	N
Adult Day Health Care	N	Abortions	N

	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	Total
Rate Calculation							
1. Average Cost Per Unit							
2. Units per Eligible/year							
Cost per Elig. per Mo.							
3. Adjustments							
a. Age/Sex							
b. Area							
c. Coverages							
d. Interest							
Adjusted Base Cost							
4. Legislative Adjustments							
5. Trend Adjustments							
Projected Cost per Eligible							
6. Adjustment to Pool							
Total Capitation Rate							
Adjustment for Abortions							
Net Capitation Rate							

Prepared by Department of Health Services, Rate Development Branch

Plan Name:	Molina Medical Center	Plan #:	356	Date: 22-Sep-03
County:	San Bernardino	Plan Type:	Commercial Plan	
Aid Code Grouping:	Disabled			

The Rate Period is August 1, 2003 to September 30, 2003

Capitation Payments at the End of the Month

Coverages (C = Covered by Plan, N = NOT Covered by Plan)

CCS Indicated Claims	N	Newborn Hearing Screening	N
GHPP	N	MH - Hospital Inpatient	N
Hemodialysis	C	MH - Outpatient Services	N
Major Organ Transplant	N	MH - Psychotropic Drugs	N
Chiropractor	N	Psychiatrist	N
Acupuncturist	N	LTC Month of Entry Plus 1	C
Lenses for Eyeware	N	LTC After Month of Entry Plus 1	N
Local Education Authority	N	Targeted Case Management	N
Alphafeto Protein Testing	N	Short-Doyle Mental Health	N
Direct Observed Therapy	N	Multipurpose Senior Support Program	N
Heroin Detoxification	N	Services at State or Federal Hospitals	N
AIDS Waiver	N	Out of State Services	C
Special AIDS Drugs	N	Childhood Lead Screening	C
In Home Waiver	N	CHDP Services	C
Model NF Waiver	N	Home/Community Based Services	N
Adult Day Health Care	N	Abortions	N

	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	Total
Rate Calculation							
1. Average Cost Per Unit							
2. Units per Eligible/year							
Cost per Elig. per Mo.							
3. Adjustments							
a. Age/Sex							
b. Area							
c. Coverages							
d. Interest							
Adjusted Base Cost							
4. Legislative Adjustments							
5. Trend Adjustments							
Projected Cost per Eligible							
6. Adjustment to Pool							
Total Capitation Rate							
Adjustment for Abortions							
Net Capitation Rate							

Prepared by Department of Health Services, Rate Development Branch

Plan Name:	Molina Medical Center	Plan #:	356	Date: 22-Sep-03
County:	San Bernardino	Plan Type:	Commercial Plan	
Aid Code Grouping:	Aged			

The Rate Period is August 1, 2003 to September 30, 2003

Capitation Payments at the End of the Month

Coverages (C = Covered by Plan, N = NOT Covered by Plan)

CCS Indicated Claims	N	Newborn Hearing Screening	N
GHPP	N	MH - Hospital Inpatient	N
Hemodialysis	C	MH - Outpatient Services	N
Major Organ Transplant	N	MH - Psychotropic Drugs	N
Chiropractor	N	Psychiatrist	N
Acupuncturist	N	LTC Month of Entry Plus 1	C
Lenses for Eyeware	N	LTC After Month of Entry Plus 1	N
Local Education Authority	N	Targeted Case Management	N
Alphafeto Protein Testing	N	Short-Doyle Mental Health	N
Direct Observed Therapy	N	Multipurpose Senior Support Program	N
Heroin Detoxification	N	Services at State or Federal Hospitals	N
AIDS Waiver	N	Out of State Services	C
Special AIDS Drugs	N	Childhood Lead Screening	C
In Home Waiver	N	CHDP Services	C
Model NF Waiver	N	Home/Community Based Services	N
Adult Day Health Care	N	Abortions	N

	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	Total
Rate Calculation							
1. Average Cost Per Unit							
2. Units per Eligible/year							
Cost per Elig. per Mo.							
3. Adjustments							
a. Age/Sex							
b. Area							
c. Coverages							
d. Interest							
Adjusted Base Cost							
4. Legislative Adjustments							
5. Trend Adjustments							
Projected Cost per Eligible							
6. Adjustment to Pool							
Total Capitation Rate							
Adjustment for Abortions							
Net Capitation Rate							

Prepared by Department of Health Services, Rate Development Branch

Plan Name:	Molina Medical Center	Plan #: 356	Date: 22-Sep-03
County:	San Bernardino	Plan Type: Commercial Plan	
Aid Code Grouping:	Child		

The Rate Period is August 1, 2003 to September 30, 2003

Capitation Payments at the End of the Month

Coverages (C = Covered by Plan, N = NOT Covered by Plan)

CCS Indicated Claims	N	Newborn Hearing Screening	N
GHPP	N	MH - Hospital Inpatient	N
Hemodialysis	C	MH - Outpatient Services	N
Major Organ Transplant	N	MH - Psychotropic Drugs	N
Chiropractor	N	Psychiatrist	N
Acupuncturist	N	LTC Month of Entry Plus 1	C
Lenses for Eyeware	N	LTC After Month of Entry Plus 1	N
Local Education Authority	N	Targeted Case Management	N
Alphafeto Protein Testing	N	Short-Doyle Mental Health	N
Direct Observed Therapy	N	Multipurpose Senior Support Program	N
Heroin Detoxification	N	Services at State or Federal Hospitals	N
AIDS Waiver	N	Out of State Services	C
Special AIDS Drugs	N	Childhood Lead Screening	C
In Home Waiver	N	CHDP Services	C
Model NF Waiver	N	Home/Community Based Services	N
Adult Day Health Care	N	Abortions	N

	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	Total
Rate Calculation							
1. Average Cost Per Unit							
2. Units per Eligible/year							
Cost per Elig. per Mo.							
3. Adjustments							
a. Age/Sex							
b. Area							
c. Coverages							
d. Interest							
Adjusted Base Cost							
4. Legislative Adjustments							
5. Trend Adjustments							
Projected Cost per Eligible							
6. Adjustment to Pool							
Total Capitation Rate							
Adjustment for Abortions							
Net Capitation Rate							

Prepared by Department of Health Services, Rate Development Branch

Plan Name:	Molina Medical Center	Plan #: 356	Date: 22-Sep-03
County:	San Bernardino	Plan Type: Commercial Plan	
Aid Code Grouping:	Adult		

The Rate Period is August 1, 2003 to September 30, 2003

Capitation Payments at the End of the Month

Coverages (C = Covered by Plan, N = NOT Covered by Plan)

CCS Indicated Claims	N	Newborn Hearing Screening	N
GHPP	N	MH - Hospital Inpatient	N
Hemodialysis	C	MH - Outpatient Services	N
Major Organ Transplant	N	MH - Psychotropic Drugs	N
Chiropractor	N	Psychiatrist	N
Acupuncturist	N	LTC Month of Entry Plus 1	C
Lenses for Eyeware	N	LTC After Month of Entry Plus 1	N
Local Education Authority	N	Targeted Case Management	N
Alphafeto Protein Testing	N	Short-Doyle Mental Health	N
Direct Observed Therapy	N	Multipurpose Senior Support Program	N
Heroin Detoxification	N	Services at State or Federal Hospitals	N
AIDS Waiver	N	Out of State Services	C
Special AIDS Drugs	N	Childhood Lead Screening	C
In Home Waiver	N	CHDP Services	C
Model NF Waiver	N	Home/Community Based Services	N
Adult Day Health Care	N	Abortions	N

	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	Total
Rate Calculation							
1. Average Cost Per Unit							
2. Units per Eligible/year							
Cost per Elig. per Mo.							
3. Adjustments							
a. Age/Sex							
b. Area							
c. Coverages							
d. Interest							
Adjusted Base Cost							
4. Legislative Adjustments							
5. Trend Adjustments							
Projected Cost per Eligible							
6. Adjustment to Pool							
Total Capitation Rate							
Adjustment for Abortions							
Net Capitation Rate							

Prepared by Department of Health Services, Rate Development Branch

Plan Name:	Molina Medical Center	Plan #: 356	Date: 22-Sep-03
County:	San Bernardino	Plan Type: Commercial Plan	
Aid Code Grouping:	AIDS		

The Rate Period is August 1, 2003 to September 30, 2003

Capitation Payments at the End of the Month

Coverages (C = Covered by Plan, N = NOT Covered by Plan)

CCS Indicated Claims	N	Newborn Hearing Screening	N
GHPP	N	MH - Hospital Inpatient	N
Hemodialysis	C	MH - Outpatient Services	N
Major Organ Transplant	N	MH - Psychotropic Drugs	N
Chiropractor	N	Psychiatrist	N
Acupuncturist	N	LTC Month of Entry Plus 1	C
Lenses for Eyeware	N	LTC After Month of Entry Plus 1	N
Local Education Authority	N	Targeted Case Management	N
Alphafeto Protein Testing	N	Short-Doyle Mental Health	N
Direct Observed Therapy	N	Multipurpose Senior Support Program	N
Heroin Detoxification	N	Services at State or Federal Hospitals	N
AIDS Waiver	N	Out of State Services	C
Special AIDS Drugs	N	Childhood Lead Screening	C
In Home Waiver	N	CHDP Services	C
Model NF Waiver	N	Home/Community Based Services	N
Adult Day Health Care	N	Abortions	N

	Physician	Pharmacy	Hospital Inpatient	Hospital Outpatient	Long Term Care	Other	Total
Rate Calculation							
1. Average Cost Per Unit							
2. Units per Eligible/year							
Cost per Elig. per Mo.							
3. Adjustments							
a. Age/Sex							
b. Area							
c. Coverages							
d. Interest							
Adjusted Base Cost							
4. Legislative Adjustments							
5. Trend Adjustments							
Projected Cost per Eligible							
6. Adjustment to Pool							
Total Capitation Rate							
Adjustment for Abortions							
Net Capitation Rate							

Prepared by Department of Health Services, Rate Development Branch

GTC 103

EXHIBIT C

GENERAL TERMS AND CONDITIONS

1. APPROVAL: This Agreement is of no force or effect until signed by both parties and approved by the Department of General Services, if required. Contractor may not commence performance until such approval has been obtained.

2. AMENDMENT: No amendment or variation of the terms of this Agreement shall be valid unless made in writing, signed by the parties and approved as required. No oral understanding or Agreement not incorporated in the Agreement is binding on any of the parties.

3. ASSIGNMENT: This Agreement is not assignable by the Contractor, either in whole or in part, without the consent of the State in the form of a formal written amendment.

4. AUDIT: Contractor agrees that the awarding department, the Department of General Services, the Bureau of State Audits, or their designated representative shall have the right to review and to copy any records and supporting documentation pertaining to the performance of this Agreement. Contractor agrees to maintain such records for possible audit for a minimum of three (3) years after final payment, unless a longer period of records retention is stipulated. Contractor agrees to allow the auditor(s) access to such records during normal business hours and to allow interviews of any employees who might reasonably have information related to such records. Further, Contractor agrees to include a similar right of the State to audit records and interview staff in any subcontract related to performance of this Agreement. (GC 8546.7, PCC 10115 et seq., CCR Title 2, Section 1896).

5. INDEMNIFICATION: Contractor agrees to indemnify, defend and save harmless the State, its officers, agents and employees from any and all claims and losses accruing or resulting to any and all contractors, subcontractors, suppliers, laborers, and any other person, firm or corporation furnishing or supplying work services, materials, or supplies in connection with the performance of this Agreement, and from any and all claims and losses accruing or resulting to any person, firm or corporation who may be injured or damaged by Contractor in the performance of this Agreement.

6. DISPUTES: Contractor shall continue with the responsibilities under this Agreement during any dispute.

7. TERMINATION FOR CAUSE: The State may terminate this Agreement and be relieved of any payments should the Contractor fail to perform the requirements of this Agreement at the time and in the manner herein provided. In the event of such termination the State may proceed with the work in any manner deemed proper by the State. All costs to the State shall be deducted from any sum due the Contractor under this Agreement and the balance, if any, shall be paid to the Contractor upon demand.

8. INDEPENDENT CONTRACTOR: Contractor, and the agents and employees of Contractor, in the performance of this Agreement, shall act in an independent capacity and not as officers or employees or agents of the State.

9. RECYCLING CERTIFICATION: The Contractor shall certify in writing under penalty of perjury, the minimum, if not exact, percentage of recycled content, both post consumer waste and secondary waste as defined in the Public Contract Code, Sections 12161 and 12200, in materials, goods, or supplies offered or products used in the performance of this Agreement, regardless of whether the product meets the required recycled product percentage as defined in the Public Contract Code, Sections 12161 and 12200. Contractor may certify that the product contains zero recycled content. (PCC 10233, 10308.5, 10354)

10. NON-DISCRIMINATION CLAUSE: During the performance of this Agreement, Contractor and its subcontractors shall not unlawfully discriminate, harass, or allow harassment against any employee or applicant for employment because of sex, race, color, ancestry, religious creed, national origin, physical disability (including HIV and AIDS), mental disability, medical condition (cancer), age (over 40), marital status, and denial of family care leave. Contractor and subcontractors shall insure that the evaluation and treatment of their employees and applicants for employment are free from such discrimination and harassment. Contractor and subcontractors shall comply with the provisions of the Fair Employment and Housing Act (Government Code Section 12990 (a-f) et seq.) and the applicable regulations promulgated thereunder (California Code of Regulations, Title 2, Section 7285 et seq.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code Section 12990 (a-f), set forth in Chapter 5 of Division 4 of Title 2 of the California Code of Regulations, are incorporated into this Agreement by reference and made a part hereof as if set forth in full. Contractor and its subcontractors shall give written notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other Agreement.

Contractor shall include the nondiscrimination and compliance provisions of this clause in all subcontracts to perform work under the Agreement.

11. CERTIFICATION CLAUSES: The CONTRACTOR CERTIFICATION CLAUSES contained in the document CCC 103 are hereby incorporated by reference and made a part of this Agreement by this reference as if attached hereto.

12. TIMELINESS: Time is of the essence in this Agreement.

13. COMPENSATION: The consideration to be paid Contractor, as provided herein, shall be in compensation for all of Contractor's expenses incurred in the performance hereof, including travel, per diem, and taxes, unless otherwise expressly so provided.

14. GOVERNING LAW: This contract is governed by and shall be interpreted in accordance with the laws of the State of California.

15. ANTITRUST CLAIMS: The Contractor by signing this agreement hereby certifies that if these services or goods are obtained by means of a competitive bid, the Contractor shall comply with the requirements of the Government Codes Sections set out below.

a. The Government Code Chapter on Antitrust claims contains the following definitions:

1). "Public purchase" means a purchase by means of competitive bids of goods, services, or materials by the State or any of its political subdivisions or public agencies on whose behalf the Attorney General may bring an action pursuant to subdivision (c) of Section 16750 of the Business and Professions Code.

2). "Public purchasing body" means the State or the subdivision or agency making a public purchase. Government Code Section 4550.

b. In submitting a bid to a public purchasing body, the bidder offers and agrees that if the bid is accepted, it will assign to the purchasing body all rights, title, and interest in and to all causes of action it may have under Section 4 of the Clayton Act (15 U.S.C. Sec. 15) or under the Cartwright Act (Chapter 2 (commencing with Section 16700) of Part 2 of Division 7 of the Business and Professions Code), arising from purchases of goods, materials, or services by the bidder for sale to the purchasing body pursuant to the bid. Such assignment shall be made and become effective at the time the purchasing body tenders final payment to the bidder. Government Code Section 4552.

c. If an awarding body or public purchasing body receives, either through judgment or settlement, a monetary recovery for a cause of action assigned under this chapter, the assignor shall be entitled to receive reimbursement for actual legal costs incurred and may, upon demand, recover from the public body any portion of the recovery, including treble damages, attributable to overcharges that were paid by the assignor but were not paid by the public body as part of the bid price, less the expenses incurred in obtaining that portion of the recovery. Government Code Section 4553.

d. Upon demand in writing by the assignor, the assignee shall, within one year from such demand, reassign the cause of action assigned under this part if the assignor has been or may have been injured by the violation of law for which the cause of action arose and (a) the assignee has not been injured thereby, or (b) the assignee declines to file a court action for the cause of action. See Government Code Section 4554.

16. CHILD SUPPORT COMPLIANCE ACT: "For any Agreement in excess of $100,000, the contractor acknowledges in accordance with, that:

a). The contractor recognizes the importance of child and family support obligations and shall fully comply with all applicable state and federal laws relating to child and family support enforcement, including, but not limited to, disclosure of information and compliance with earnings assignment orders, as provided in Chapter 8 (commencing with section 5200) of Part 5 of Division 9 of the Family Code; and

b) The contractor, to the best of its knowledge is fully complying with the earnings assignment orders of all employees and is providing the names of all new employees to the New Hire Registry maintained by the California Employment Development Department."

17. UNENFORCEABLE PROVISION: In the event that any provision of this Agreement is unenforceable or held to be unenforceable, then the parties agree that all other provisions of this Agreement have force and effect and shall not be effected thereby.

18. UNION ACTIVITIES For all contracts, except fixed price contracts of $50,000 or less, the Contractor acknowledges that:

By signing this agreement Contractor hereby acknowledges the applicability of Government Code Section 16645 through Section 16649 to this agreement and agrees to the following:

a) Contractor will not assist, promote or deter union organizing by employees performing work on a state service contract, including a public works contract.

b) No state funds received under this agreement will be used to assist, promote or deter union organizing.

c) Contractor will not, for any business conducted under this agreement, use any state property to hold meetings with employees or supervisors, if the purpose of such meetings is to assist, promote or deter union organizing, unless the state property is equally available to the general public for holding meetings.

d) If Contractor incurs costs, or makes expenditures to assist, promote or deter union organizing, Contractor will maintain records sufficient to show that no reimbursement from state funds has been sought for these costs, and that Contractor shall provide those records to the Attorney General upon request.

Special Terms and Conditions

(For federally funded service contracts and grant awards)

The use of headings or titles throughout this exhibit is for convenience only and shall not be used to interpret or to govern the meaning of any specific term or condition. The terms "contract", "Contractor" and "Subcontractor" shall also mean "grant", "Grantee" and "Subgrantee" respectively.

Index of Special Terms and Conditions

1. Federal Equal Opportunity Requirements

(Applicable to all federally funded agreements.)

a. The Contractor will not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. The Contractor will take affirmative action to ensure that qualified applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Such action shall include, but not be limited to the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship. The Contractor agrees to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the Federal Government or DHS, setting forth the provisions of the Equal Opportunity clause, Section 503 of the Rehabilitation Act of 1973 and the affirmative action clause required by the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212). Such notices shall state the Contractor's obligation under the law to take affirmative action to employ and advance in employment qualified applicants without discrimination based on their race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era and the rights of applicants and employees.

b. The Contractor will, in all solicitations or advancements for employees placed by or on behalf of the Contractor, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era.

c. The Contractor will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the Federal Government or the State, advising the labor union or workers' representative of the Contractor's commitments under the provisions herein and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

d. The Contractor will comply with all provisions of and furnish all information and reports required by Section 503 of the Rehabilitation Act of 1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212) and of the Federal Executive Order No. 11246 as amended, and of the rules, regulations, and relevant orders of the Secretary of Labor.

e. The Contractor will furnish all information and reports required by Federal Executive Order No. 11246 as amended, and the Rehabilitation Act of 1973, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to its books, records, and accounts by the State and its designated representatives and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.

f. In the event of the Contractor's noncompliance with the requirements of the provisions herein or with any federal rules, regulations, or orders which are referenced herein, this agreement may be cancelled, terminated, or suspended in whole or in part and the Contractor may be declared ineligible for further federal and state contracts in accordance with procedures authorized in Federal Executive Order No. 11246 as amended and such other sanctions may be imposed and remedies invoked as provided in Federal Executive Order No. 11246 as amended, or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.

g. The Contractor will include the provisions of Paragraphs a through g in every subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor issued pursuant to Federal Executive Order No. 11246 as amended, or Section 503 of the Rehabilitation Act of 1973 or (38 U.S.C. 4212) of the Vietnam Era Veteran's Readjustment Assistance Act, so that such provisions will be binding upon each subcontractor or vendor. The Contractor will take such action with respect to any subcontract or purchase order as the Director of the Office of Federal Contract Compliance Programs or DHS may direct as a means of enforcing such

provisions including sanctions for noncompliance provided, however, that in the event the Contractor becomes involved in, or is threatened with litigation by a subcontractor or vendor as a result of such direction by DHS, the Contractor may request in writing to DHS, who, in turn, may request the United States to enter into such litigation to protect the interests of the State and of the United States.

2. Travel and Per Diem Reimbursement

(Applicable if travel and/or per diem expenses are reimbursed with contract funds.)

Reimbursement for travel and per diem expenses from DHS under this agreement shall, unless otherwise specified in this agreement, be at the rates currently in effect, as established by the California Department of Personnel Administration (DPA), for nonrepresented state employees. If the DPA rates change during the term of the agreement, the new rates shall apply upon their effective date and no amendment to this agreement shall be necessary. Exceptions to DPA rates may be approved by DHS upon the submission of a statement by the Contractor indicating that such rates are not available to the Contractor. No travel outside the State of California shall be reimbursed without prior written authorization from DHS.

3. Procurement Rules

(Applicable to all agreements in which equipment, miscellaneous property, commodities and/or supplies are furnished by DHS or expenses for said items are reimbursed with state or federal funds.)

a. **Equipment definitions**

Wherever the term equipment and/or miscellaneous property is used, the following definitions shall apply:

(1) **Major equipment:** A tangible or intangible item having a base unit cost of **$5,000 or more** with a life expectancy of one (1) year or more and is either furnished by DHS or the cost is reimbursed through this agreement. Software and videos are examples of intangible items that meet this definition.

(2) **Minor equipment:** A tangible item having a base unit cost of **less than $5,000** with a life expectancy of one (1) year or more that is listed on the DHS Asset Management Unit's Minor Equipment List and is either furnished by DHS or the cost is reimbursed through this agreement. Contractors may obtain a copy of the Minor Equipment List by making a request through the DHS program contract manager.

(3) **Miscellaneous property:** A specific tangible item with a life expectancy of one (1) year or more that is either furnished by DHS or the cost is reimbursed through this agreement. Examples include, but are not limited to: furniture (excluding modular furniture), cabinets, typewriters, desktop calculators, portable dictators, non-digital cameras, etc.

b. **Government and public entities** (including state colleges/universities and auxiliary organizations), whether acting as a contractor and/or subcontractor, may secure all commodities, supplies, equipment and services related to such purchases that are required in performance of this agreement. Said procurements are subject to Paragraphs d through h of Provision 3. Paragraph c of Provision 3 shall also apply, if equipment purchases are delegated to subcontractors that are nonprofit organizations or commercial businesses.

c. **Nonprofit organizations and commercial businesses,** whether acting as a contractor and/or subcontractor, may secure commodities, supplies, equipment and services related to such purchases for performance under this agreement.

(1) Equipment purchases shall not exceed $50,000 annually.

To secure equipment above the annual maximum limit of $50,000, the Contractor shall make arrangements through the appropriate DHS program contract manager, to have all remaining

equipment purchased through DHS' Purchasing Unit. The cost of equipment purchased by or through DHS shall be deducted from the funds available in this agreement. Contractor shall submit to the DHS program contract manager a list of equipment specifications for those items that the State must procure. The State may pay the vendor directly for such arranged equipment purchases and title to the equipment will remain with DHS. The equipment will be delivered to the Contractor's address, as stated on the face of the agreement, unless the Contractor notifies the DHS program contract manager, in writing, of an alternate delivery address.

(2) All equipment purchases are subject to Paragraphs d through h of Provision 3. Paragraph b of Provision 3 shall also apply, if equipment purchases are delegated to subcontractors that are either a government or public entity.

(3) Nonprofit organizations and commercial businesses, shall use a procurement system that meets the following standards:

(a) Maintain a code or standard of conduct that shall govern the performance of its officers, employees, or agents engaged in awarding procurement contracts. No employee, officer, or agent shall participate in the selection, award, or administration of a procurement contract in which, to his or her knowledge, he or she has a financial interest.

(b) Procurements shall be conducted in a manner that provides, to the maximum extent practical, open, and free competition.

(c) Procurements shall be conducted in a manner that provides for all of the following:

[1] Avoid purchasing unnecessary or duplicate items.

[2] Equipment solicitations shall be based upon a clear and accurate description of the technical requirements of the goods to be procured.

[3] Take positive steps to utilize small and veteran owned businesses.

d. Unless waived or otherwise stipulated in writing by DHS, prior written authorization from the appropriate DHS program contract manager will be required before the Contractor will be reimbursed for any purchase of $5,000 or more for commodities, supplies, equipment, and services related to such purchases. The Contractor must provide in its request for authorization all particulars necessary, as specified by DHS, for evaluating the necessity or desirability of incurring such costs. The term "purchase" excludes the purchase of services from a subcontractor and public utility services at rates established for uniform applicability to the general public.

e. In special circumstances, determined by DHS (e.g., when DHS has a need to monitor certain purchases, etc.), DHS may require prior written authorization and/or the submission of paid vendor receipts for any purchase, regardless of dollar amount. DHS reserves the right to either deny claims for reimbursement or to request repayment for any Contractor and/or subcontractor purchase that DHS determines to be unnecessary in carrying out performance under this agreement.

f. The Contractor and/or subcontractor must maintain a copy or narrative description of the procurement system, guidelines, rules, or regulations that will be used to make purchases under this agreement. The State reserves the right to request a copy of these documents and to inspect the purchasing practices of the Contractor and/or subcontractor at any time.

g. For all purchases, the Contractor and/or subcontractor must maintain copies of all paid vendor invoices, documents, bids and other information used in vendor selection, for inspection or audit. Justifications supporting the absence of bidding (i.e., sole source purchases) shall also be maintained on file by the Contractor and/or subcontractor for inspection or audit.

h. DHS may, with cause (e.g., with reasonable suspicion of unnecessary purchases or use of inappropriate purchase practices, etc.), withhold, cancel, modify, or retract the delegated purchase authority granted under Paragraphs b and/or c of Provision 3 by giving the Contractor no less than 30 calendar days written notice.

4. Equipment Ownership / Inventory / Disposition

(Applicable to agreements in which equipment and/or miscellaneous property is furnished by DHS and/or when said items are purchased or reimbursed with state or federal funds.)

a. Wherever the term equipment and/or miscellaneous property is used in Provision 4, the definitions in Provision 3, Paragraph a shall apply.

All equipment and/or miscellaneous property that are purchased/reimbursed with agreement funds or furnished by DHS under the terms of this agreement and not fully consumed in performance of this agreement shall be considered state equipment and the property of DHS.

(1) DHS requires the reporting, tagging and annual inventorying of all equipment and/or miscellaneous property that is furnished by DHS or purchased/reimbursed with funds provided through this agreement.

Upon receipt of equipment and/or miscellaneous property, the Contractor shall report the receipt to the DHS program contract manager. To report the receipt of said items and to receive property tags, Contractor shall use a form or format designated by DHS' Asset Management Unit. If the appropriate form (i.e., Contractor Equipment Purchased with DHS Funds) does not accompany this agreement, Contractor shall request a copy from the DHS program contract manager.

(2) If the Contractor enters into an agreement with a term of more than twelve months, the Contractor shall submit an annual inventory of state equipment and/or miscellaneous property to the DHS program contract manager using a form or format designated by DHS' Asset Management Unit. If an inventory report form (i.e., Inventory/Disposition of DHS-Funded Equipment) does not accompany this agreement, Contractor shall request a copy from the DHS program contract manager. Contractor shall:

(a) Include in the inventory report, equipment and/or miscellaneous property in the Contractor's possession and/or in the possession of a subcontractor (including independent consultants).

(b) Submit the inventory report to DHS according to the instructions appearing on the inventory form or issued by the DHS program contract manager.

(c) Contact the DHS program contract manager to learn how to remove, trade-in, sell; transfer or survey off, from the inventory report, expired equipment and/or miscellaneous property that is no longer wanted, usable or has passed its life expectancy. Instructions will be supplied by DHS' Asset Management Unit.

b. Title to state equipment and/or miscellaneous property shall not be affected by its incorporation or attachment to any property not owned by the State.

c. Unless otherwise stipulated, DHS shall be under no obligation to pay the cost of restoration, or rehabilitation of the Contractor's and/or Subcontractor's facility which may be affected by the removal of any state equipment and/or miscellaneous property.

d. The Contractor and/or Subcontractor shall maintain and administer a sound business program for ensuring the proper use, maintenance, repair, protection, insurance and preservation of state equipment and/or miscellaneous property.

(1) In administering this provision, DHS may require the Contractor and/or Subcontractor to repair or replace, to DHS' satisfaction, any damaged, lost or stolen state equipment and/or

miscellaneous property. Contractor and/or Subcontractor shall immediately file a theft report with the appropriate police agency or the California Highway Patrol and Contractor shall promptly submit one copy of the theft report to the DHS program contract manager.

e. Unless otherwise stipulated by the program funding this agreement, equipment and/or miscellaneous property purchased/reimbursed with agreement funds or furnished by DHS under the terms of this agreement, shall only be used for performance of this agreement or another DHS agreement.

f. Within sixty (60) calendar days prior to the termination or end of this agreement, the Contractor shall provide a final inventory report of equipment and/or miscellaneous property to the DHS program contract manager and shall, at that time, query DHS as to the requirements, including the manner and method, of returning state equipment and/or miscellaneous property to DHS. Final disposition of equipment and/or miscellaneous property shall be at DHS expense and according to DHS instructions. Equipment and/or miscellaneous property disposition instructions shall be issued by DHS immediately after receipt of the final inventory report. At the termination or conclusion of this agreement, DHS may at its discretion, authorize the continued use of state equipment and/or miscellaneous property for performance of work under a different DHS agreement.

g. Motor Vehicles

(Applicable only if motor vehicles are purchased/reimbursed with agreement funds or furnished by DHS under this agreement.)

(1) If motor vehicles are purchased/reimbursed with agreement funds or furnished by DHS under the terms of this agreement, within thirty (30) calendar days prior to the termination or end of this agreement, the Contractor and/or Subcontractor shall return such vehicles to DHS and shall deliver all necessary documents of title or registration to enable the proper transfer of a marketable title to DHS.

(2) If motor vehicles are purchased/reimbursed with agreement funds or furnished by DHS under the terms of this agreement, the State of California shall be the legal owner of said motor vehicles and the Contractor shall be the registered owner. The Contractor and/or a subcontractor may only use said vehicles for performance and under the terms of this agreement.

(3) The Contractor and/or Subcontractor agree that all operators of motor vehicles, purchased/reimbursed with agreement funds or furnished by DHS under the terms of this agreement, shall hold a valid State of California driver's license. In the event that ten or more passengers are to be transported in any one vehicle, the operator shall also hold a State of California Class B driver's license.

(4) If any motor vehicle is purchased/reimbursed with agreement funds or furnished by DHS under the terms of this agreement, the Contractor and/or Subcontractor, as applicable, shall provide, maintain, and certify that, at a minimum, the following type and amount of automobile liability insurance is in effect during the term of this agreement or any period of contract extension during which any vehicle remains in the Contractor's and/or Subcontractor's possession:

Automobile Liability Insurance

(a) The Contractor, by signing this agreement, hereby certifies that it possesses or will obtain automobile liability insurance in the amount of $1,000,000 per occurrence for bodily injury and property damage combined. Said insurance must be obtained and made effective upon the delivery date of any motor vehicle, purchased/reimbursed with agreement funds or furnished by DHS under the terms of this agreement, to the Contractor and/or Subcontractor.

(b) The Contractor and/or Subcontractor shall, as soon as practical, furnish a copy of the certificate of insurance to the DHS program contract manager.

(c) The Contractor and/or Subcontractor agree that bodily injury and property damage liability insurance, as required herein, shall remain in effect at all times during the term of this agreement or until such time as the motor vehicle is returned to DHS.

(d) The Contractor and/or Subcontractor agree to provide, at least thirty (30) days prior to the expiration date of said insurance coverage, a copy of a new certificate of insurance evidencing continued coverage, as indicated herein, for not less than the remainder of the term of this agreement, the term of any extension or continuation thereof, or for a period of not less than one (1) year.

(e) The Contractor and/or Subcontractor, if not a self-insured government and/or public entity, must provide evidence, that any required certificates of insurance contain the following provisions:

[1] The insurer will not cancel the insured's coverage without giving thirty (30) calendar days prior written notice to the State (California Department of Health Services).

[2] The State of California, its officers, agents, employees, and servants are included as additional insureds, but only with respect to work performed for the State under this agreement and any extension or continuation of this agreement.

[3] The insurance carrier shall notify the State of California Department of Health Services, in writing, of the Contractor's failure to pay premiums; its cancellation of such policies; or any other substantial change, including, but not limited to, the status, coverage, or scope of the required insurance. Such notices shall contain a reference to the agreement number for which the insurance was obtained.

(f) The Contractor and/or Subcontractor is hereby advised that copies of certificates of insurance may be subject to review and approval by the Department of General Services (DGS), Office of Risk and Insurance Management. The Contractor shall be notified by DHS, in writing, if this provision is applicable to this agreement. If DGS approval of the certificate of insurance is required, the Contractor agrees that no work or services shall be performed prior to obtaining said approval.

(g) In the event the Contractor and/or Subcontractor fails to keep insurance coverage, as required herein, in effect at all times during vehicle possession, DHS may, in addition to any other remedies it may have, terminate this agreement upon the occurrence of such event.

5. Subcontract Requirements

(Applicable to agreements under which services are to be performed by subcontractors including independent consultants.)

a. Prior written authorization will be required before the Contractor enters into or is reimbursed for any subcontract for services costing $5,000 or more. Except as indicated in Paragraph a(3) herein, when securing subcontracts for services exceeding $5,000, the Contractor shall obtain at least three bids or justify a sole source award.

(1) The Contractor must provide in its request for authorization, all particulars necessary for evaluating the necessity or desirability of incurring such cost.

(2) The State may identify the information needed to fulfill this requirement.

(3) Subcontracts performed by the following entities or for the service types listed below are exempt from the bidding and sole source justification requirements:

(a) A local governmental entity or the federal government,

(b) A State college or university from any State,

(c) A Joint Powers Authority,

(d) An auxiliary organization of a California State University or a California community college,

(e) A foundation organized to support the Board of Governors of the California Community Colleges,

(f) An auxiliary organization of the Student Aid Commission established under Education Code § 69522,

(g) Entities of any type that will provide subvention aid or direct services to the public,

(h) Entities and/or service types identified as exempt from advertising in State Administrative Manual Section 1233 subsection 3. View this publication at the following Internet address: http://sam.dgs.ca.gov.

(4) Unless otherwise mandated by the funding agency (i.e., federal government), DHS may only pay the Contractor's overhead charges or indirect costs on the first $25,000 of each subcontract.

b. DHS reserves the right to approve or disapprove the selection of subcontractors and with advance written notice, require the substitution of subcontractors and require the Contractor to terminate subcontracts entered into in support of this agreement.

(1) Upon receipt of a written notice from DHS requiring the substitution and/or termination of a subcontract, the Contractor shall take steps to ensure the completion of any work in progress and select a replacement, if applicable, within 30 calendar days, unless a longer period is agreed to by DHS.

c. Actual subcontracts (i.e., written agreement between the Contractor and a subcontractor) of $5,000 or more are subject to the prior review and written approval of DHS. DHS may, at its discretion, elect to waive this right. All such waivers shall be confirmed in writing by DHS.

d. Contractor shall maintain a copy of each subcontract entered into in support of this agreement and shall, upon request by DHS, make said copies available for approval, inspection, or audit.

e. Sole responsibility rests with the Contractor to ensure that subcontractors, used in performance of this agreement, are paid in a timely manner. The timeliness of said payments may be affected by the timeliness of payments issued by DHS to the Contractor.

f. The Contractor is responsible for all performance requirements under this agreement even though performance may be carried out through a subcontract.

g. The Contractor shall ensure that all subcontracts for services include provision(s) requiring compliance with applicable terms and conditions specified in this agreement.

h. The Contractor agrees to include the following clause, relevant to record retention, in all subcontracts for services:

"(Subcontractor Name) agrees to maintain and preserve, until three years after termination of *(Agreement Number)* and final payment from DHS, to permit DHS or any duly authorized representative, to have access to, examine or audit any pertinent books, documents, papers and records related to this subcontract and to allow interviews of any employees who might reasonably have information related to such records."

i. Unless otherwise stipulated in writing by DHS, the Contractor shall be the subcontractor's sole point of contact for all matters related to performance and payment under this agreement.

j. Contractor shall, as applicable, advise all subcontractors of their obligations pursuant to the following numbered provisions of this Exhibit: 1, 2, 3, 4, 5, 6, 7, 8, 10, 11, 12, 13, 14, 17, 19, 20, 24, and 32.

6. Income Restrictions

Unless otherwise stipulated in this agreement, the Contractor agrees that any refunds, rebates, credits, or other amounts (including any interest thereon) accruing to or received by the Contractor under this agreement shall be paid by the Contractor to DHS, to the extent that they are properly allocable to costs for which the Contractor has been reimbursed by DHS under this agreement.

7. Audit and Record Retention

(Applicable to agreements in excess of $10,000.)

a. The Contractor and/or Subcontractor shall maintain books, records, documents, and other evidence, accounting procedures and practices, sufficient to properly reflect all direct and indirect costs of whatever nature claimed to have been incurred in the performance of this agreement, including any matching costs and expenses. The foregoing constitutes "records" for the purpose of this provision.

b. The Contractor's and/or subcontractor's facility or office or such part thereof as may be engaged in the performance of this agreement and his/her records shall be subject at all reasonable times to inspection, audit, and reproduction.

c. Contractor agrees that DHS, the Department of General Services, the Bureau of State Audits, or their designated representatives including the Comptroller General of the United States shall have the right to review and to copy any records and supporting documentation pertaining to the performance of this agreement. Contractor agrees to allow the auditor(s) access to such records during normal business hours and to allow interviews of any employees who might reasonably have information related to such records. Further, the Contractor agrees to include a similar right of the State to audit records and interview staff in any subcontract related to performance of this agreement. (GC 8546.7, CCR Title 2, Section 1896).

d. The Contractor and/or Subcontractor shall preserve and make available his/her records (1) for a period of three years from the date of final payment under this agreement, and (2) for such longer period, if any, as is required by applicable statute, by any other provision of this agreement, or by subparagraphs (1) or (2) below.

(1) If this agreement is completely or partially terminated, the records relating to the work terminated shall be preserved and made available for a period of three years from the date of any resulting final settlement.

(2) If any litigation, claim, negotiation, audit, or other action involving the records has been started before the expiration of the three-year period, the records shall be retained until completion of the action and resolution of all issues which arise from it, or until the end of the regular three-year period, whichever is later.

e. The Contractor and/or Subcontractor shall comply with the above requirements and be aware of the penalties for violations of fraud and for obstruction of investigation as set forth in Public Contract Code § 10115.10, if applicable.

f. The Contractor and/or Subcontractor may, at its discretion, following receipt of final payment under this agreement, reduce its accounts, books and records related to this agreement to microfilm, computer disk, CD ROM, or other data storage medium. Upon request by an authorized representative to inspect, audit or obtain copies of said records, the Contractor and/or Subcontractor must supply or make available applicable devices, hardware, and/or software necessary to view, copy and/or print said records. Applicable devices may include, but are not limited to, microfilm readers and microfilm printers, etc.

8. Site Inspection

The State, through any authorized representatives, has the right at all reasonable times to inspect or otherwise evaluate the work performed or being performed hereunder including subcontract supported activities and the premises in which it is being performed. If any inspection or evaluation is made of the premises of the Contractor or Subcontractor, the Contractor shall provide and shall require Subcontractors to provide all reasonable facilities and assistance for the safety and convenience of the authorized representatives in the performance of their duties. All inspections and evaluations shall be performed in such a manner as will not unduly delay the work.

9. Federal Contract Funds

(Applicable only to that portion of an agreement funded in part or whole with federal funds.)

a. It is mutually understood between the parties that this agreement may have been written before ascertaining the availability of congressional appropriation of funds, for the mutual benefit of both parties, in order to avoid program and fiscal delays which would occur if the agreement were executed after that determination was made.

b. This agreement is valid and enforceable only if sufficient funds are made available to the State by the United States Government for the fiscal years covered by the term of this agreement. In addition, this agreement is subject to any additional restrictions, limitations, or conditions enacted by the Congress or any statute enacted by the Congress which may affect the provisions, terms or funding of this agreement in any manner.

c. It is mutually agreed that if the Congress does not appropriate sufficient funds for the program, this agreement shall be amended to reflect any reduction in funds.

d. DHS has the option to void or cancel the agreement with 30-days advance written notice or to amend the agreement to reflect any reduction in funds.

10. Intellectual Property Rights

a. Ownership

(1) Except where DHS has agreed in a signed writing to accept a license, DHS shall be and remain, without additional compensation, the sole owner of any and all rights, title and interest in all Intellectual Property, from the moment of creation, whether or not jointly conceived, that are made, conceived, derived from, or reduced to practice by Contractor or DHS and which result directly or indirectly from this agreement.

(2) For the purposes of this agreement, Intellectual Property means recognized protectable rights and interest such as: patents, (whether or not issued) copyrights, trademarks, service marks, applications for any of the foregoing, inventions, trade secrets, trade dress, logos, insignia, color combinations, slogans, moral rights, right of publicity, author's rights, contract and licensing rights, works, mask works, industrial design rights, rights of priority, know how, design flows, methodologies, devices, business processes, developments, innovations, good will and all other legal rights protecting intangible proprietary information as may exist now and/or here after come into existence, and all renewals and extensions, regardless of whether those rights arise under the laws of the United States, or any other state, country or jurisdiction.

(a) For the purposes of the definition of Intellectual Property, "works" means all literary works, writings and printed matter including the medium by which they are recorded or reproduced, photographs, art work, pictorial and graphic representations and works of a similar nature, film, motion pictures, digital images, animation cells, and other audiovisual works including positives and negatives thereof, sound recordings, tapes, educational materials, interactive videos and any other materials or products created, produced, conceptualized and fixed in a tangible medium of expression. It includes preliminary and final products and any materials and information developed for the purposes of producing

those final products. Works does not include articles submitted to peer review or reference journals or independent research projects.

(3) In the performance of this agreement, Contractor will exercise and utilize certain of its Intellectual Property in existence prior to the effective date of this agreement. In addition, under this agreement, Contractor may access and utilize certain of DHS' Intellectual Property in existence prior to the effective date of this agreement. Except as otherwise set forth herein, Contractor shall not use any of DHS' Intellectual Property now existing or hereafter existing for any purposes without the prior written permission of DHS. **Except as otherwise set forth herein, neither the Contractor nor DHS shall give any ownership interest in or rights to its Intellectual Property to the other Party.** If during the term of this agreement, Contractor accesses any third-party Intellectual Property that is licensed to DHS, Contractor agrees to abide by all license and confidentiality restrictions applicable to DHS in the third-party's license agreement.

(4) Contractor agrees to cooperate with DHS in establishing or maintaining DHS' exclusive rights in the Intellectual Property, and in assuring DHS' sole rights against third parties with respect to the Intellectual Property. If the Contractor enters into any agreements or subcontracts with other parties in order to perform this agreement, Contractor shall require the terms of the agreement(s) to include all Intellectual Property provisions. Such terms must include, but are not limited to, the subcontractor assigning and agreeing to assign to DHS all rights, title and interest in Intellectual Property made, conceived, derived from, or reduced to practice by the subcontractor, Contractor or DHS and which result directly or indirectly from this agreement or any subcontract.

(5) Contractor further agrees to assist and cooperate with DHS in all reasonable respects, and execute all documents and, subject to reasonable availability, give testimony and take all further acts reasonably necessary to acquire, transfer, maintain, and enforce DHS' Intellectual Property rights and interests.

b. Retained Rights / License Rights

(1) Except for Intellectual Property made, conceived, derived from, or reduced to practice by Contractor or DHS and which result directly or indirectly from this agreement, Contractor shall retain title to all of its Intellectual Property to the extent such Intellectual Property is in existence prior to the effective date of this agreement. Contractor hereby grants to DHS, without additional compensation, a permanent, non-exclusive, royalty free, paid-up, worldwide, irrevocable, perpetual, non-terminable license to use, reproduce, manufacture, sell, offer to sell, import, export, modify, publicly and privately display/perform, distribute, and dispose Contractor's Intellectual Property with the right to sublicense through multiple layers, for any purpose whatsoever, to the extent it is incorporated in the Intellectual Property resulting from this agreement, unless Contractor assigns all rights, title and interest in the Intellectual Property as set forth herein.

(2) Nothing in this provision shall restrict, limit, or otherwise prevent Contractor from using any ideas, concepts, know-how, methodology or techniques related to its performance under this agreement, provided that Contractor's use does not infringe the patent, copyright, trademark rights, license or other Intellectual Property rights of DHS or third party, or result in a breach or default of any provisions of this Exhibit or result in a breach of any provisions of law relating to confidentiality.

c. Copyright

(1) Contractor agrees that for purposes of copyright law, all works [as defined in Section a, subparagraph (2)(a) of this provision] of authorship made by or on behalf of Contractor in connection with Contractor's performance of this agreement shall be deemed "works made for hire". Contractor further agrees that the work of each person utilized by Contractor in connection with the performance of this agreement will be a "work made for hire," whether that person is an employee of Contractor or that person has entered into an agreement with Contractor to perform the work. Contractor shall enter into a written agreement with any such

person that: (i) all work performed for Contractor shall be deemed a "work made for hire" under the Copyright Act and (ii) that person shall assign all right, title, and interest to DHS to any work product made, conceived, derived from, or reduced to practice by Contractor or DHS and which result directly or indirectly from this agreement.

(2) All materials, including, but not limited to, visual works or text, reproduced or distributed pursuant to this agreement that include Intellectual Property made, conceived, derived from, or reduced to practice by Contractor or DHS and which result directly or indirectly from this agreement, shall include DHS' notice of copyright, which shall read in 3mm or larger typeface: "© 2001, State of California, Department of Health Services. This material may not be reproduced or disseminated without prior written permission from the Department of Health Services." This notice should be placed prominently on the materials and set apart from other matter on the page where it appears. Audio productions shall contain a similar audio notice of copyright.

d. Patent Rights

With respect to inventions made by Contractor in the performance of this agreement, which did not result from research and development specifically included in the agreement's scope of work, Contractor hereby grants to DHS a license as described under Section b of this provision for devices or material incorporating, or made through the use of such inventions. If such inventions result from research and development work specifically included within the agreement's scope of work, then Contractor agrees to assign to DHS, without additional compensation, all its right, title and interest in and to such inventions and to assist DHS in securing United States and foreign patents with respect thereto.

e. Third-Party Intellectual Property

Except as provided herein, Contractor agrees that its performance of this agreement shall not be dependent upon or include any Intellectual Property of Contractor or third party without first: (i) obtaining DHS' prior written approval; and (ii) granting to or obtaining for DHS, without additional compensation, a license, as described in Section b of this provision, for any of Contractor's or third-party's Intellectual Property in existence prior to the effective date of this agreement. If such a license upon the these terms is unattainable, and DHS determines that the Intellectual Property ¦ should be included in or is required for Contractor's performance of this agreement, Contractor shall obtain a license under terms acceptable to DHS.

f. Warranties

(1) Contractor represents and warrants that:

(a) It is free to enter into and fully perform this agreement.

(b) It has secured and will secure all rights and licenses necessary for its performance of this agreement.

(c) Neither Contractor's performance of this agreement, nor the exercise by either Party of the rights granted in this agreement, nor any use, reproduction, manufacture, sale, offer to sell, import, export, modification, public and private display/performance, distribution, and disposition of the Intellectual Property made, conceived, derived from, or reduced to practice by Contractor or DHS and which result directly or indirectly from this agreement will infringe upon or violate any Intellectual Property right, non-disclosure obligation, or other proprietary right or interest of any third-party or entity now existing under the laws of, or hereafter existing or issued by, any state, the United States, or any foreign country. There is currently no actual or threatened claim by any such third party based on an alleged violation of any such right by Contractor.

(d) Neither Contractor's performance nor any part of its performance will violate the right of privacy of, or constitute a libel or slander against any person or entity.

(e) It has secured and will secure all rights and licenses necessary for Intellectual Property including, but not limited to, consents, waivers or releases from all authors of music or performances used, and talent (radio, television and motion picture talent), owners of any interest in and to real estate, sites, locations, property or props that may be used or shown.

(f) It has not granted and shall not grant to any person or entity any right that would or might derogate, encumber, or interfere with any of the rights granted to DHS in this agreement.

(g) It has appropriate systems and controls in place to ensure that state funds will not be used in the performance of this agreement for the acquisition, operation or maintenance of computer software in violation of copyright laws.

(h) It has no knowledge of any outstanding claims, licenses or other charges, liens, or encumbrances of any kind or nature whatsoever that could affect in any way Contractor's performance of this agreement.

(2) DHS MAKES NO WARRANTY THAT THE INTELLECTUAL PROPERTY RESULTING FROM THIS AGREEMENT DOES NOT INFRINGE UPON ANY PATENT, TRADEMARK, COPYRIGHT OR THE LIKE, NOW EXISTING OR SUBSEQUENTLY ISSUED.

g. Intellectual Property Indemnity

(1) Contractor shall indemnify, defend and hold harmless DHS and its licensees and assignees, and its officers, directors, employees, agents, representatives, successors, and users of its products, ("Indemnitees") from and against all claims, actions, damages, losses, liabilities (or actions or proceedings with respect to any thereof), whether or not rightful, arising from any and all actions or claims by any third party or expenses related thereto (including, but not limited to, all legal expenses, court costs, and attorney's fees incurred in investigating, preparing, serving as a witness in, or defending against, any such claim, action, or proceeding, commenced or threatened) to which any of the Indemnitees may be subject, whether or not Contractor is a party to any pending or threatened litigation, which arise out of or are related to (i) the incorrectness or breach of any of the representations, warranties, covenants or agreements of Contractor pertaining to Intellectual Property; or (ii) any Intellectual Property infringement, or any other type of actual or alleged infringement claim, arising out of DHS' use, reproduction, manufacture, sale, offer to sell, distribution, import, export, modification, public and private performance/display, license, and disposition of the Intellectual Property made, conceived, derived from, or reduced to practice by Contractor or DHS and which result directly or indirectly from this agreement. This indemnity obligation shall apply irrespective of whether the infringement claim is based on a patent, trademark or copyright registration that issued after the effective date of this agreement. DHS reserves the right to participate in and/or control, at Contractor's expense, any such infringement action brought against DHS.

(2) Should any Intellectual Property licensed by the Contractor to DHS under this agreement become the subject of an Intellectual Property infringement claim, Contractor will exercise its authority reasonably and in good faith to preserve DHS' right to use the licensed Intellectual Property in accordance with this agreement at no expense to DHS. DHS shall have the right to monitor and appear through its own counsel (at Contractor's expense) in any such claim or action. In the defense or settlement of the claim, Contractor may obtain the right for DHS to continue using the licensed Intellectual Property; or, replace or modify the licensed Intellectual Property so that the replaced or modified Intellectual Property becomes non-infringing provided that such replacement or modification is functionally equivalent to the original licensed Intellectual Property. If such remedies are not reasonably available, DHS shall be entitled to a refund of all monies paid under this agreement, without restriction or limitation of any other rights and remedies available at law or in equity.

(3) Contractor agrees that damages alone would be inadequate to compensate DHS for breach of any term of this Intellectual Property Exhibit by Contractor. Contractor acknowledges DHS would suffer irreparable harm in the event of such breach and agrees DHS shall be entitled to

obtain equitable relief, including without limitation an injunction, from a court of competent jurisdiction, without restriction or limitation of any other rights and remedies available at law or in equity.

h. Federal Funding

In any agreement funded in whole or in part by the federal government, DHS may acquire and maintain the Intellectual Property rights, title, and ownership, which results directly or indirectly from the agreement; except as provided in 37 Code of Federal Regulations part 401.14; however, the federal government shall have a non-exclusive, nontransferable, irrevocable, paid-up license throughout the world to use, duplicate, or dispose of such Intellectual Property throughout the world in any manner for governmental purposes and to have and permit others to do so.

i. Survival

The provisions set forth herein shall survive any termination or expiration of this agreement or any project schedule.

11. Air or Water Pollution Requirements

Any federally funded agreement and/or subcontract in excess of $100,000 must comply with the following provisions unless said agreement is exempt under 40 CFR 15.5.

a. Government contractors agree to comply with all applicable standards, orders, or requirements issued under section 306 of the Clean Air Act [42 U.S.C. 1857(h)], section 508 of the Clean Water Act (33 U.S.C. 1368), Executive Order 11738, and Environmental Protection Agency regulations (40 CFR part 15).

b. Institutions of higher education, hospitals, nonprofit organizations and commercial businesses agree to comply with all applicable standards, orders, or requirements issued under the Clean Air Act (42 U.S.C. 7401 et seq.), as amended, and the Federal Water Pollution Control Act (33 U.S.C. 1251 et seq.), as amended.

12. Prior Approval of Training Seminars, Workshops or Conferences

Contractor shall obtain prior DHS approval of the location, costs, dates, agenda, instructors, instructional materials, and attendees at any reimbursable training seminar, workshop, or conference conducted pursuant to this contract and of any reimbursable publicity or educational materials to be made available for distribution. The Contractor shall acknowledge the support of the State whenever publicizing the work under this agreement in any media. This provision does not apply to necessary staff meetings or training sessions held for the staff of the Contractor or Subcontractor to conduct routine business matters.

13. Confidentiality of Information

a. The Contractor and its employees, agents, or subcontractors shall protect from unauthorized disclosure names and other identifying information concerning persons either receiving services pursuant to this agreement or persons whose names or identifying information become available or are disclosed to the Contractor, its employees, agents, or subcontractors as a result of services performed under this agreement, except for statistical information not identifying any such person.

b. The Contractor and its employees, agents, or subcontractors shall not use such identifying information for any purpose other than carrying out the Contractor's obligations under this agreement.

c. The Contractor and its employees, agents, or subcontractors shall promptly transmit to the DHS program contract manager all requests for disclosure of such identifying information not emanating from the client or person.

d. The Contractor shall not disclose, except as otherwise specifically permitted by this agreement or authorized by the client, any such identifying information to anyone other than DHS without prior written authorization from the DHS program contract manager.

e. For purposes of this provision, identity shall include, but not be limited to name, identifying number, symbol, or other identifying particular assigned to the individual, such as finger or voice print or a photograph.

14. Documents, Publications and Written Reports

(Applicable to agreements over $5,000 under which publications, written reports and documents are developed or produced. Government Code Section 7550.)

Any document, publication or written report (excluding progress reports, financial reports and normal contract communications) prepared as a requirement of this agreement shall contain, in a separate section preceding the main body of the document, the number and dollar amounts of all contracts and subcontracts relating to the preparation of such document or report, if the total cost for work by nonemployees of the State exceeds $5,000.

15. Dispute Resolution Process

a. A Contractor grievance exists whenever the Contract believes there is a dispute arising from DHS' action in the administration of an agreement. If the Contractor believes there is a dispute or grievance between the Contractor and DHS, both parties shall follow the procedure outlined below.

(1) The Contractor should first discuss the problem informally with the DHS program contract manager. If the problem cannot be resolved at this stage, the Contractor shall direct its grievance together with any evidence, in writing, to the program Branch Chief. The grievance shall state the issues in dispute, the legal authority or other basis for the Contractor's position and the remedy sought. The Branch Chief shall make a determination on the problem within ten (10) working days after receipt of the written communication from the Contractor. The Branch Chief shall respond in writing to the Contractor indicating the decision and reasons therefore. Should the Contractor disagree with the Branch Chief's decision, the Contractor may appeal to the second level.

(2) The Contractor must prepare a letter indicating the reasons for disagreement with Branch Chief's decision. The Contractor shall include with the letter a copy of the Contractor's original statement of dispute with any supporting documents and a copy of the Branch Chief's response. This letter shall be sent to the Deputy Director of the division in which the branch is organized within ten (10) working days from receipt of the Branch Chief's decision. The Deputy Director of the division funding this agreement or his/her designee shall meet with the Contractor to review the issues raised. A written decision signed by the Deputy Director of the division funding this agreement or his/her designee shall be returned to the Contractor within twenty (20) working days of receipt of the Contractor's letter.

b. If the Contractor wishes to appeal the decision of the Deputy Director of the division funding this agreement or his/her designee, the Contractor shall follow the procedures set forth in Division 25.1 (commencing with Section 38050) of the Health and Safety Code and the regulations adopted thereunder. (Title 1, Subchapter 2.5, commencing with Section 251, California Code of Regulations.)

c. Disputes arising out of an audit, examination of an agreement or other action not covered by subdivision (a) of Section 20204, of Chapter 2.1, Title 22, of the California Code of Regulations, and for which no procedures for appeal are provided in statute, regulation or the agreement, shall be handled in accordance with the procedures identified in Sections 51016 through 51047, Title 22, California Code of Regulations.

d. Unless otherwise stipulated by DHS, dispute, grievance and/or appeal correspondence shall be directed to the DHS program contract manager.

16. Financial and Compliance Audit Requirements

a. The definitions used in this provision are contained in Section 38040 of the Health and Safety Code, which by this reference is made a part hereof.

b. Direct service contract means a contract for services contained in local assistance or subvention programs or both (see Health and Safety [H&S] Code section 38020). Direct service contracts shall not include contracts, grants, or subventions to other governmental agencies or units of government nor contracts with regional centers or area agencies on aging (H&S Code section 38030).

c. The Contractor, as indicated below, agrees to obtain one of the following audits:

(1) If the Contractor is a nonprofit organization (as defined in H&S Code section 38040) and receives **$25,000 or more** from any State agency under a direct service contract; the Contractor agrees to obtain an annual single, organization wide, financial and compliance audit. Said audit shall be conducted according to Generally Accepted Auditing Standards. This audit does not fulfill the audit requirements of Paragraph c(3) below. The audit shall be completed by the 15th day of the fifth month following the end of the Contractor's fiscal year, **and/or**

(2) If the Contractor is a nonprofit organization (as defined in H&S Code section 38040) and receives **less than $25,000** per year from any State agency under a direct service contract, the Contractor agrees to obtain a biennial single, organization wide financial and compliance audit, unless there is evidence of fraud or other violation of state law in connection with this agreement. This audit does not fulfill the audit requirements of Paragraph c(3) below. The audit shall be completed by the 15th day of the fifth month following the end of the Contractor's fiscal year, **and/or**

(3) If the Contractor is a State or Local Government entity or Nonprofit organization (as defined by the Federal Office of Management and Budget [OMB] Circular A-133) and expends $300,000 or more in Federal awards, the Contractor agrees to obtain an annual single, organization wide, financial and compliance audit according to the requirements specified in OMB Circular A-133 entitled "Audits of States, Local Governments, and Non-Profit Organizations". An audit conducted pursuant to this provision will fulfill the audit requirements outlined in Paragraphs c(1) and c(2) above. The audit shall be completed by the end of the ninth month following the end of the audit period. The requirements of this provision apply if:

(a) The Contractor is a recipient expending Federal awards received directly from Federal awarding agencies, or

(b) The Contractor is a subrecipient expending Federal awards received from a pass-through entity such as the State, County or community based organization.

(4) If the Contractor submits to DHS a report of an audit other than an OMB A-133 audit, the Contractor must also submit a certification indicating the Contractor has not expended $300,000 or more in federal funds for the year covered by the audit report.

d. Two copies of the audit report shall be delivered to the DHS program funding this agreement. The audit report must identify the Contractor's legal name and the number assigned to this agreement. The audit report shall be due within 30 days after the completion of the audit. Upon receipt of said audit report, the DHS program contract manager shall forward the audit report to DHS' Audits and Investigations Unit.

e. The cost of the audits described herein may be included in the funding for this agreement up to the proportionate amount this agreement represents of the Contractor's total revenue. The DHS program funding this agreement must provide advance written approval of the specific amount allowed for said audit expenses.

f. The State or its authorized designee, including the Bureau of State Audits, is responsible for conducting agreement performance audits which are not financial and compliance audits. Performance audits are defined by Generally Accepted Government Auditing Standards.

g. Nothing in this agreement limits the State's responsibility or authority to enforce State law or regulations, procedures, or reporting requirements arising thereto.

h. Nothing in this provision limits the authority of the State to make audits of this agreement, provided however, that if independent audits arranged for by the Contractor meet Generally Accepted Governmental Auditing Standards, the State shall rely on those audits and any additional audit work and shall build upon the work already done.

i. The State may, at its option, direct its own auditors to perform either of the audits described above. The Contractor will be given advance written notification, if the State chooses to exercise its option to perform said audits.

j. The Contractor shall include a clause in any agreement the Contractor enters into with the audit firm doing the single organization wide audit to provide access by the State or Federal Government to the working papers of the independent auditor who prepares the single organization wide audit for the Contractor.

k. Federal or state auditors shall have "expanded scope auditing" authority to conduct specific program audits during the same period in which a single organization wide audit is being performed, but the audit report has not been issued. The federal or state auditors shall review and have access to the current audit work being conducted and will not apply any testing or review procedures which have not been satisfied by previous audit work that has been completed.

   The term "expanded scope auditing" is applied and defined in the U.S. General Accounting Office (GAO) issued Standards for *Audit of Government Organizations, Programs, Activities and Functions,* better known as the "yellow book".

17. Human Subjects Use Requirements

(Applicable only to federally funded agreements/grants in which performance, directly or through a subcontract/subaward, includes any tests or examination of materials derived from the human body.)

By signing this agreement, Contractor agrees that if any performance under this agreement or any subcontract or subagreement includes any tests or examination of materials derived from the human body for the purpose of providing information, diagnosis, prevention, treatment or assessment of disease, impairment, or health of a human being, all locations at which such examinations are performed shall meet the requirements of 42 U.S.C. Section 263a (CLIA) and the regulations thereunder.

18. Novation Requirements

If the Contractor proposes any novation agreement, DHS shall act upon the proposal within 60 days after receipt of the written proposal. DHS may review and consider the proposal, consult and negotiate with the Contractor, and accept or reject all or part of the proposal. Acceptance or rejection of the proposal may be made orally within the 60-day period and confirmed in writing within five days of said decision. Upon written acceptance of the proposal, DHS will initiate an amendment to this agreement to formally implement the approved proposal.

19. Debarment and Suspension Certification

(Applicable to all agreements funded in part or whole with federal funds.)

a. By signing this agreement, the Contractor/Grantee agrees to comply with applicable federal suspension and debarment regulations including, but not limited to 7 CFR Part 3017, 45 CFR 76, 40 CFR 32 or 34 CFR 85.

b. By signing this agreement, the Contractor certifies to the best of its knowledge and belief, that it and its principals:

(1) Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any federal department or agency;

(2) Have not within a three-year period preceding this application/proposal/agreement been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

(3) Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in Paragraph b(2) herein; and

(4) Have not within a three-year period preceding this application/proposal/agreement had one or more public transactions (Federal, State or local) terminated for cause or default.

(5) Shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under federal regulations (i.e., 48 CFR part 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State.

(6) Will include a clause entitled, "Debarment and Suspension Certification" that essentially sets forth the provisions herein, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

c. If the Contractor is unable to certify to any of the statements in this certification, the Contractor shall submit an explanation to the DHS program funding this contract.

d. The terms and definitions herein have the meanings set out in the Definitions and Coverage sections of the rules implementing Federal Executive Order 12549.

e. If the Contractor knowingly violates this certification, in addition to other remedies available to the Federal Government, the DHS may terminate this agreement for cause or default.

20. Smoke-Free Workplace Certification

(Applicable to federally funded agreements/grants and subcontracts/subawards, that provide health, day care, early childhood development services, education or library services to children under 18 directly or through local governments.)

a. Public Law 103-227, also known as the Pro-children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by federal programs either directly or through state or local governments, by federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed.

b. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible party.

c. By signing this agreement, Contractor or Grantee certifies that it will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The prohibitions herein are effective December 26, 1994.

d. Contractor or Grantee further agrees that it will insert this certification into any subawards (subcontracts or subgrants) entered into that provide for children's services as described in the Act.

21. Covenant Against Contingent Fees

(Applicable only to federally funded agreements.)

The Contractor warrants that no person or selling agency has been employed or retained to solicit/secure this agreement upon an agreement of understanding for a commission, percentage, brokerage, or contingent fee, except *bona fide* employees or *bona fide* established commercial or selling agencies retained by the Contractor for the purpose of securing business. For breach or violation of this warranty, DHS shall have the right to annul this agreement without liability or in its discretion to deduct from the agreement price or consideration, or otherwise recover, the full amount of such commission, percentage, and brokerage or contingent fee.

22. Payment Withholds

(Applicable only if a final report is required by this agreement. Not applicable to government entities.)

Unless waived or otherwise stipulated in this contract, DHS may, at its discretion, withhold 10 percent (10%) of the face amount of the agreement, 50 percent (50%) of the final invoice, or $3,000 whichever is greater, until DHS receives a final report that meets the terms, conditions and/or scope of work requirements of this agreement.

23. Performance Evaluation

(Not applicable to grant agreements.)

DHS may, at its discretion, evaluate the performance of the Contractor at the conclusion of this agreement. If performance is evaluated, the evaluation shall not be a public record and shall remain on file with DHS. Negative performance evaluations may be considered by DHS prior to making future contract awards.

24. Officials Not to Benefit

No members of or delegate of Congress or the State Legislature shall be admitted to any share or part of this agreement, or to any benefit that may arise therefrom. This provision shall not be construed to extend to this agreement if made with a corporation for its general benefits.

25. Year 2000 Compliance

(Applicable to agreements in which Information Technology (IT) services are provided to DHS or if IT equipment is procured.)

The Contractor warrants and represents that the goods or services sold, leased, or licensed to the State of California, its agencies, or its political subdivisions, pursuant to this agreement are "Year 2000 Compliant." For the purposes of this agreement, a good or services is Year 2000 compliant if it will continue to fully function before, at, and after the Year 2000 without interruption and, if applicable, with full ability to accurately and unambiguously process, display, compare, calculate, manipulate, and otherwise utilize date information. This warranty and representation supersedes all warranty disclaimers and limitations and all limitations on liability provided by or through the Contractor.

26. Prohibited Use of State Funds for Software

(Applicable to agreements in which computer software is used in performance of the work.)

Contractor certifies that it has appropriate systems and controls in place to ensure that state funds will not be used in the performance of this agreement for the acquisition, operation or maintenance of computer software in violation of copyright laws.

27. University of California Mutual Indemnification

(Applicable only to agreements entered with the Regents of the University of California or a University of California campus under its jurisdiction.)

a. The State and the Regents of the University of California shall mutually defend, indemnify and hold each other and their respective agencies, officers, employees, and agents harmless from and against any and all liability, loss, expense, attorneys' fees, or claims for injury or damages arising out of the performance of this contract but only in proportion to and to the extent such liability, loss, expense, attorneys' fees, or claims for injury or damages are caused by or result from the negligent or intentional acts or omissions of either the State or the Regents of the University of California.

b. It should be expressly understood that the obligations hereunder shall be conditioned upon this contract being one that falls within the purview of Section 895 of the Government Code.

28. Use of Small, Minority Owned and Women's Businesses

(Applicable to that portion of an agreement that is federally funded and entered into with institutions of higher education, hospitals, nonprofit organizations or commercial businesses.)

Positive efforts shall be made to use small businesses, minority-owned firms and women's business enterprises, whenever possible (i.e., procurement of goods and/or services). Contractors shall take all of the following steps to further this goal.

(1) Ensure that small businesses, minority-owned firms, and women's business enterprises are used to the fullest extent practicable.

(2) Make information on forthcoming purchasing and contracting opportunities available and arrange time frames for purchases and contracts to encourage and facilitate participation by small businesses, minority-owned firms, and women's business enterprises.

(3) Consider in the contract process whether firms competing for larger contracts intend to subcontract with small businesses, minority-owned firms, and women's business enterprises.

(4) Encourage contracting with consortiums of small businesses, minority-owned firms and women's business enterprises when a contract is too large for one of these firms to handle individually.

(5) Use the services and assistance, as appropriate, of such organizations as the Federal Small Business Administration and the U.S. Department of Commerce's Minority Business Development Agency in the solicitation and utilization of small businesses, minority-owned firms and women's business enterprises.

29. Alien Ineligibility Certification

(Applicable to sole proprietors entering federally funded agreements.)

By signing this agreement, the Contractor certifies that he/she is not an alien that is ineligible for state and local benefits, as defined in Subtitle B of the Personal Responsibility and Work Opportunity Act. (8 U.S.C. 1601, et seq.)

30. Union Organizing

(Applicable only to grant agreements.)

Grantee, by signing this agreement, hereby acknowledges the applicability of Government Code 16645 through 16649 to this agreement. Furthermore, Grantee, by signing this agreement, hereby certifies that:

a. No state funds disbursed by this grant will be used to assist, promote or deter union organizing.

b. Grantee shall account for state funds disbursed for a specific expenditure by this grant, to show those funds were allocated to that expenditure.

c. Grantee shall, where state funds are not designated as described in b herein, allocate, on a pro-rata basis, all disbursements that support the grant program.

d. If Grantee makes expenditures to assist, promote or deter union organizing, Grantee will maintain records sufficient to show that no state funds were used for those expenditures, and that Grantee shall provide those records to the Attorney General upon request.

31. Contract Uniformity (Fringe Benefit Allowability)

(Applicable only to nonprofit organizations.)

Pursuant to the provisions of Article 7 (commencing with Section 100525) of Chapter 3 of Part 1 of Division 101 of the Health and Safety Code, DHS sets forth the following policies, procedures, and guidelines regarding the reimbursement of fringe benefits.

a. As used herein fringe benefits shall mean an employment benefit given by one's employer to an employee in addition to one's regular or normal wages or salary.

b. As used herein, fringe benefits do not include:

(1) Compensation for personal services paid currently or accrued by the Contractor for services of employees rendered during the term of this agreement, which is identified as regular or normal salaries and wages, annual leave, vacation, sick leave, holidays, jury duty and/or military leave/training.

(2) Director's and executive committee member's fees.

(3) Incentive awards and/or bonus incentive pay.

(4) Allowances for off-site pay.

(5) Location allowances.

(6) Hardship pay.

(7) Cost-of-living differentials

c. Specific allowable fringe benefits include:

(1) Fringe benefits in the form of employer contributions for the employer's portion of payroll taxes (i.e., FICA, SUI, SDI), employee health plans (i.e., health, dental and vision), unemployment insurance, worker's compensation insurance, and the employer's share of pension/retirement plans, provided they are granted in accordance with established written organization policies and meet all legal and Internal Revenue Service requirements.

d. To be an allowable fringe benefit, the cost must meet the following criteria:

(1) Be necessary and reasonable for the performance of the agreement.

(2) Be determined in accordance with generally accepted accounting principles.

(3) Be consistent with policies that apply uniformly to all activities of the Contractor.

e. Contractor agrees that all fringe benefits shall be at actual cost.

f. Earned/Accrued Compensation

(1) Compensation for vacation, sick leave and holidays is limited to that amount earned/accrued within the agreement term. Unused vacation, sick leave and holidays earned from periods prior to the agreement term cannot be claimed as allowable costs. See Provision f (3)(a) for an example.

(2) For multiple year contracts, vacation and sick leave compensation, which is earned/accrued but not paid, due to employee(s) not taking time off may be carried over and claimed within the overall term of the multiple years of the agreement. Holidays cannot be carried over from one contract year to the next. See Provision f (3)(b) for an example.

(3) For single year agreements, vacation, sick leave and holiday compensation that is earned/accrued but not paid, due to employee(s) not taking time off within the term of the agreement, cannot be claimed as an allowable cost. See Provision f (3)(c) for an example.

(a) **Example No. 1:**

If an employee, John Doe, earns/accrues three weeks of vacation and twelve days of sick leave each year, then that is the maximum amount that may be claimed during a contract period of one year. If John Doe has five weeks of vacation and eighteen days of sick leave at the beginning of the agreement, the Contractor during a one-year agreement term may only claim up to three weeks of vacation and twelve days of sick leave actually used by the employee. Amounts earned/accrued in periods prior to the beginning of the agreement are not an allowable cost.

(b) **Example No. 2:**

If during a three-year (multiple year) agreement, John Doe does not use his three weeks of vacation in year one, or his three weeks in year two, but he does actually use nine weeks in year three; the Contractor would be allowed to claim all nine weeks paid for in year three. The total compensation over the three-year period cannot exceed 156 weeks (3 x 52 weeks).

(c) **Example No. 3:**

If during a single year agreement, John Doe works fifty weeks and used one week of vacation and one week of sick leave and all fifty-two weeks have been billed to DHS, the remaining unused two weeks of vacation and seven days of sick leave may not be claimed as an allowable cost.

32. Lobbying Restrictions and Disclosure Certification

(Applicable to federally funded contracts in excess of $100,000 per Section 1352 of the 31, U.S.C.)

a. Certification and Disclosure Requirements

(1) Each person (or recipient) who requests or receives a contract, subcontract, grant, or subgrant, which is subject to Section 1352 of the 31, U.S.C, and which exceeds $100,000 at any tier, shall file a certification (in the form set forth in Attachment 1, consisting of one page, entitled "Certification Regarding Lobbying") that the recipient has not made, and will not make, any payment prohibited by Paragraph b of this provision.

(2) Each recipient shall file a disclosure (in the form set forth in Attachment 2, entitled "Standard Form-LLL 'disclosure of Lobbying Activities'") if such recipient has made or has agreed to make any payment using nonappropriated funds (to include profits from any covered federal action) in connection with a contract or grant or any extension or amendment of that contract or grant, which would be prohibited under Paragraph b of this provision if paid for with appropriated funds.

(3) Each recipient shall file a disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affect the accuracy of the information contained in any disclosure form previously filed by such person under Paragraph a(2) herein. An event that materially affects the accuracy of the information reported includes:

(a) A cumulative increase of $25,000 or more in the amount paid or expected to be paid for influencing or attempting to influence a covered federal action;

(b) A change in the person(s) or individuals(s) influencing or attempting to influence a covered federal action; or

(c) A change in the officer(s), employee(s), or member(s) contacted for the purpose of influencing or attempting to influence a covered federal action.

(4) Each person (or recipient) who requests or receives from a person referred to in Paragraph a(1) of this provision a contract, subcontract, grant or subgrant exceeding $100,000 at any tier under a contract or grant shall file a certification, and a disclosure form, if required, to the next tier above.

(5) All disclosure forms (but not certifications) shall be forwarded from tier to tier until received by the person referred to in Paragraph a(1) of this provision. That person shall forward all disclosure forms to DHS program contract manager.

b. Prohibition

Section 1352 of Title 31, U.S.C., provides in part that no appropriated funds may be expended by the recipient of a federal contract, grant, loan, or cooperative agreement to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any of the following covered federal actions: the awarding of any federal contract, the making of any federal grant, the making of any federal loan, entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

Attachment 1

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH SERVICES

CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the making, awarding or entering into of this Federal contract, Federal grant, or cooperative agreement, and the extension, continuation, renewal, amendment, or modification of this Federal contract, grant, or cooperative agreement.

(2) 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 agency of the United States Government, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, or cooperative agreement, the undersigned shall complete and submit Standard Form LLL, "Disclosure of Lobbying Activities" in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontractors, subgrants, and contracts under grants and cooperative agreements) of $100,000 or more, and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S.C., any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Name of Contractor	**Printed Name of Person Signing for Contractor**
Contract / Grant Number	**Signature of Person Signing for Contractor**
Date	**Title**

After execution by or on behalf of Contractor, please return to:

Department of Health Services
(Name of the DHS program providing the funds)
P.O. Box 942732
714 P Street
Sacramento, CA 94234-7320

Attachment 2

Approved by OMB

0348-0046

CERTIFICATION REGARDING LOBBYING

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure)

1. Type of Federal Action:
   - ☐ a. contract
   - b. grant
   - c. cooperative agreement
   - d. loan
   - e. loan guarantee
   - f. loan insurance

2. Status of Federal Action:
   - ☐ a. bid/offer/application
   - b. initial award
   - c. post-award

3. Report Type:
   - ☐ a. initial filing
   - b. material change

   For Material Change Only:

   Year ____ quarter _____
   date of last report _____

4. Name and Address of Reporting Entity:

   ☐ Prime ☐ Subawardee
   Tier _____, If known:

   Congressional District, If known:

5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:

   Congressional District, If known:

6. Federal Department/Agency:

7. Federal Program Name/Description:

   CDFA Number, if applicable: _____

8. Federal Action Number, if known:

9. Award Amount, if known:

10. a. Name and Address of Lobbying Entity
    (If individual, last name, first name, MI):

    b. Name and Address of Lobbying Entity
    (If individual, last name, first name, MI):

(attach Continuation Sheets(s) SF-LLL-A, If necessary)

11. Amount of Payment (check all that apply):

    $ _____ ☐ actual ☐ planned

12. Form of Payment (check all that apply):

    ☐ a. cash
    ☐ b. in-kind, specify: Nature_____
    Value_____

13. Type of Payment (check all that apply):

    ☐ a. retainer
    ☐ b. one-time fee
    ☐ c. commission
    ☐ d. contingent fee
    ☐ e. deferred
    ☐ f. other, specify: _____

14. Brief Description of Services Performed or to be Performed and Dates(s) of Service, including Officer(s), Employee(s), or Member(s) Contracted for Payment indicated in item 11:

(Attach Continuation Sheet(s) SF-LLL-A, If necessary)

15. Continuation Sheet(s) SF-LLL-A Attached: ☐ Yes ☐ No

16. Information requested through this form is authorized by Title 31, U.S.C., Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to Title 31, U.S.C., Section 1352. This information will be reported to the Congress semiannually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $19,000 and not more than $100,000 for each such failure.

Signature: _____

Print Name: _____

Title: _____

Telephone No.:_____ Date: _____

Federal Use Only

Authorized for Local Reproduction
Standard Form-LLL

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime federal recipients at the initiation or receipt of a covered federal action, or a material change to a previous filing, pursuant to Title 31, U.S.C., Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered federal action. Use the SF - LLL-A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered federal action.
2. Identify the status of the covered federal action.
3. Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered federal action.
4. Enter the full name, address, city, state, and ZIP code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants, and contract awards under grants.
5. If the organization filing the report in Item 4 checks "Subawardee," then enter the full name, address, city, state, and ZIP code of the prime federal recipient. Include Congressional District, if known.
6. Enter the name of the federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation United States Coast Guard.
7. Enter the federal program name or description for the covered federal action (Item 1). If known, enter the full Catalog of Federal Domestic Assistance (CDFA) number for grants, cooperative agreements, loans, and loan commitments.
8. Enter the most appropriate federal identifying number available for the federal action identified in Item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract grant, or loan award number; the application/proposal control number assigned by the federal agency). Include prefixes, e.g., "RFP-DE-90401."
9. For a covered federal action where there has been an award or loan commitment by the federal agency, enter the federal amount of the award/loan commitment for the prime entity identified in Item 4 or 5.
10. (a) Enter the full name, address, city, state, and ZIP code of the lobbying entity engaged by the reporting entity identified in Item 4 to influence the covered federal action.

10. (b) Enter the full names of the Individual(s) performing services and include full address if different from 10.(a). Enter last name, first name, and middle initial (MI).

11. Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (Item 4) to the lobbying entity (Item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.
12. Check the appropriate box(es). Check all boxes that apply. If payment is made through an in-kind contribution, specify the nature and value of the in-kind payment.
13. Check the appropriate box(es). Check all boxes that apply. If other, specify nature.
14. Provide a specific and detailed description of the services that the lobbyist has performed, or will be expected to perform, and the date(s) of any services rendered. Include all preparatory and related activity, not just time spent in actual contact with federal officials, identify the federal official(s) or employee(s) contacted or the officers), employee(s), or Member(s) of Congress that were contacted.
15. Check whether or not a SF-LLL-A Continuation Sheet(s) is attached.
16. The certifying official shall sign and date the form, print his/her name, title, and telephone number.

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including time for reviewing instruction, searching existing data sources, gathering and maintaining the data needed, and completing and renewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to the Office of Management and Budget, Paperwork Reduction Project, (0348-0046), Washington, DC 20503.

Exhibit E
Additional Provisions

1. Incorporated Exhibits

The following exhibits are attached, incorporated herein, and made a part hereof by this reference:

1) Exhibit A –	**Scope of Work**	2 pages
	Attachment 1 – Organization and Administration of the Plan	4 pages
	Attachment 2 – Financial Information	3 pages
	Attachment 3 – Management Information System	2 pages
	Attachment 4 – Quality Improvement System	11 pages
	Attachment 5 – Utilization Management	4 pages
	Attachment 6 – Provider Network	8 pages
	Attachment 7 – Provider Relations	2 pages
	Attachment 8 – Provider Compensation Arrangements	6 pages
	Attachment 9 – Access and Availability	9 pages
	Attachment 10 – Scope of Services	14 pages
	Attachment 11 – Case Management and Coordination of Care	12 pages
	Attachment 12 – Local Health Department Coordination	3 pages
	Attachment 13 – Member Services	11 pages
	Attachment 14 – Member Grievance System	2 pages
	Attachment 15 – Marketing	5 pages
	Attachment 16 – Enrollments and Disenrollments	4 pages
	Attachment 17 – Reporting Requirements	2 pages
2) Exhibit B	**Budget Detail and Payment Provisions**	14 pages
3) Exhibit C*	**General Terms and Conditions**	GTC 103
4) Exhibit D(F)	**Special Terms and Conditions** Notwithstanding provisions 2, 3, 4, 5, 6, 7, 10, 11, 12, 14, 15, 16, 22, 25, 27, 29, 30, and 31 which do not apply to this agreement.	26 pages
5) Exhibit E	**Additional Provisions**	3 pages
	Attachment 1 – Definitions	16 pages
	Attachment 2 – Program Terms and Conditions	29 pages
	Attachment 3 – Duties of the State	7 pages
6) Exhibit F	**Contractor's Release**	1 page
7) Exhibit G	**Health Insurance Portability and Accountability Act**	5 pages

Items shown above with an Asterisk (*), are hereby incorporated by reference and made part of this agreement as if attached hereto. *These documents can be viewed at http://www.dgs.ca.gov/contracts.*

Exhibit E
Additional Provisions

2. Additional Provisions

A. In the event of a conflict between the provisions of Exhibit E and any other part of this Contract, the provisions of Exhibit E shall prevail.

B. The following Attachments are incorporated herein and made a part hereof by this reference:

Attachment 1: Definitions

Attachment 2: Program Terms and Conditions

1) Governing Law
2) Entire Agreement
3) Amendment
4) Change Requirements
5) Delegation Of Authority
6) Authority of the State
7) Fulfillment of Obligations
8) Obtaining DHS Approval
9) Certifications
10) Notices
11) Term
12) Service Area
13) Contract Extension
14) Termination for Cause and Other Terminations
15) Phaseout Requirements
16) Sanctions
17) Liquidated Damages Provisions
18) Disputes
19) Audit
20) Inspection Rights
21) Confidentiality of Information
22) Pilot Projects
23) Cost Avoidance and Post-Payment Recovery of Other Health Coverage Sources (OHCS)
24) Third-Party Tort Liability
25) Records Related To Recovery For Litigation
26) Fraud and Abuse Reporting
27) Equal Opportunity Employer
28) Discrimination Prohibitions
29) Americans With Disabilities Act Of 1990 Requirements
30) Disabled Veteran Business Enterprises (DVBE)
31) Word Usage

Exhibit E
Additional Provisions

Attachment 3: Duties of the State

1) Payment For Services
2) Medical Reviews
3) Enrollment Processing
4) Disenrollment Processing
5) Approval Process
6) Program Information
7) Catastrophic Coverage Limitation
8) Risk Limitation
9) Notice Of Termination Of Contract

Exhibit E
Definitions

Attachment 1

As used in this Contract, unless otherwise expressly provided or the context otherwise requires, the following definitions of terms will govern the construction of this Contract:

1. **Administrative Costs** means only those costs that arise out of the operation of the plan excluding direct and overhead costs incurred in the furnishing of health care services, which would ordinarily be incurred in the provision of these services whether or not through a plan.
2. **Affiliate** means an organization or person that directly or indirectly through one or more intermediaries' controls, or is controlled by, or is under control with the Contractor and that provides services to, or receives services from, the Contractor.
3. **AIDS Beneficiary** means a Member for whom a Diagnosis of Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS) has been made by a treating Physician based on the definition most recently published in the Mortality and Morbidity Report from the Centers for Disease Control and Prevention.
4. **Allied Health Personnel** means specially trained, licensed, or credentialed health workers other than Physicians, podiatrists and Nurses.
5. **Ambulatory Care** means the type of health services that are provided on an outpatient basis.
6. **Beneficiary Assignment** means the act of Department of Health Services (DHS) or DHS' enrollment contractor of notifying a beneficiary in writing of the health plan in which the beneficiary shall be enrolled if the beneficiary fails to timely choose a health plan. If, at any time, the beneficiary notifies DHS or DHS' enrollment contractor of the beneficiary's health plan choice, such choice shall override the beneficiary assignment and be effective as provided in Exhibit A, Attachment 16, provision 2.
7. **Beneficiary Identification Card (BIC)** means a permanent plastic card issued by the State to Medi-Cal recipients which is used by Contractors and providers to verify Medi-Cal eligibility and health plan enrollment.
8. **California Children Services (CCS)** means those services authorized by the CCS program for the diagnosis and treatment of the CCS eligible conditions of a specific Member.
9. **California Children Services (CCS) Eligible Conditions** means a physically handicapping condition defined in Title 22, California Code of Regulations (CCR), Section 41800.

Exhibit E
Definitions

Attachment 1

10. **California Children Services (CCS) Program** means the public health program which assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of 21 years who have CCS eligible conditions.
11. **Catastrophic Coverage Limitation** means the date beyond which Contractor is not at risk, as determined by the Director, to provide or make reimbursement for illness of or injury to beneficiaries which results from or is greatly aggravated by a catastrophic occurrence or disaster, including, but not limited to, an act of war, declared or undeclared, and which occurs subsequent to enrollment.
12. **Claims and Eligibility Real-Time System (CERTS)** means the mechanism for verifying a recipient's Medi-Cal or County Medical Services Program (CMSP) eligibility by computer.
13. **Comprehensive Medical Case Management Services** means services provided by a Primary Care Provider to ensure the coordination of Medically Necessary health care services, the provision of preventive services in accordance with established standards and periodicity schedules and the continuity of care for Medi-Cal enrollees. It includes health risk assessment, treatment planning, coordination, referral, follow-up, and monitoring of appropriate services and resources required to meet an individual's health care needs.
14. **Confidential Information** means specific facts or documents identified as "confidential" by any law, regulations or contractual language.
15. **Contract** means this written agreement between DHS and the Contractor.
16. **Contracting Providers** means a Physician, Nurse, technician, teacher, researcher, hospital, home health agency, nursing home, or any other individual or institution that contracts with Contractor to provide medical services to Members.
17. **Corrective Actions** means specific identifiable activities or undertakings of the Contractor which address program deficiencies or problems.
18. **Cost Avoid** means Contractor requires a provider to bill all liable third parties and receive payment or proof of denial of coverage from such third parties prior to Contractor paying the provider for the services rendered.

Exhibit E
Definitions

Attachment 1

19. **County Department** means the County Department of Social Services (DSS), or other county agency responsible for determining the initial and continued eligibility for the Medi-Cal program.

20. **Covered Services** means Medical Case Management and those services set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301, and Title 17, CCR, Chapter 4, Subchapter 13, Article 4, beginning with Section 6840. Covered Services do not include:

A. Services for major organ transplants as specified in Exhibit A, Attachment 11, provision 17.

B. Long-term care services as specified in Exhibit A, Attachment 11, provision 17.

C. Home and Community Based Services (HCBS) as specified in Exhibit A, Attachment 11, provision 17 regarding Waiver Programs, and Department of Developmental Services (DDS) Administered Medicaid Home and Community Based Services Waiver. *HCBS do not include any service that is available as an EPSDT service, including EPSDT supplemental services, as described in Title 22, CCR, Sections 51184, 51340 and 51340.1. EPSDT supplemental services are covered under this Contract, as specified in Exhibit A, Attachment 10 regarding Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Supplemental Services.*

D. California Children Services (CCS) as specified in Exhibit A, Attachment 11, provision 8.

E. Mental health services as specified in Exhibit A, Attachment 10, provision 7.

F. Services provided by psychiatrists; psychologists; licensed clinical social workers; marriage, family, and child counselors; or other specialty mental health provider.

G. Alcohol and substance abuse treatment services and outpatient heroin detoxification as specified in Exhibit A, Attachment 11, provision 6.

H. Fabrication of optical lenses as specified in Exhibit A, Attachment 10, provision 7.

I. Directly observed therapy for treatment of tuberculosis as specified in Exhibit A, Attachment 11, provision 15.

Exhibit E
Definitions

Attachment 1

J. Dental services as specified in Title 22, CCR, Section 51307 and EPSDT supplemental dental services as described in Title 22, CCR, Section 51340.1 (a). *However, Contractor is responsible for all Covered Services as specified in Exhibit A, Attachment 11, provision 14 regarding dental services.*

K. Acupuncture services as specified in Title 22, CCR, Section 51308.5.

L. Chiropractic services as specified in Title 22, CCR, Section 51308.

M. Prayer or spiritual healing as specified in Title 22, CCR, Section 51312.

N. Local Education Agency (LEA) assessment services as specified in Title 22, CCR, Section 51360(b) provided to a Member who qualifies for LEA services based on Title 22, CCR, Section 51190.1.

O. Any LEA services as specified in Title 22, CCR, Section 51360 provided pursuant to an Individualized Education Plan (IEP) as set forth in Education Code, Section 56340 et seq. or an Individualized Family Service Plan (IFSP) as set forth in Government Code Section 95020, or LEA services provided under an Individualized Health and Support Plan (IHSP), as described in Title 22, CCR, Section 51360.

P. Laboratory services provided under the State serum alphafetoprotein-testing program administered by the Genetic Disease Branch of DHS.

Q. Adult Day Health Care.

R. Pediatric Day Health Care.

S. Personal Care Services.

T. State Supported Services.

U. Targeted case management services as specified in Title 22, CCR, Sections 51185 and 51351, and as described in Exhibit A, Attachment 11, provision 2.

V. Childhood lead poisoning case management provided by County health departments.

W. Psychotherapeutic drugs listed in Exhibit A, Attachment 10-A (consisting of one page), and psychotherapeutic drugs classified as Anti-Psychotics and approved by the FDA after July 1,1997.

Exhibit E
Definitions

Attachment 1

X. Human Immunodeficiency Virus (HIV) and AIDS drugs listed in Exhibit A, Attachment 10-B (consisting of one page), and HIV/AIDS drugs classified as Nucleoside Analogs, Protease Inhibitors, Fusion Inhibitors and Non-Nucleoside Reverse Transcriptase Inhibitors approved by the federal Food and Drug Administration (FDA) after March 1, 2003.

21. **Credentialing** means the recognition of professional or technical competence. The process involved may include registration, certification, licensure and professional association membership.

22. **Department of Health and Human Services (DHHS)** means the federal agency responsible for management of the Medicaid program.

23. **Department of Health Services (DHS)** means the single State Department responsible for administration of the federal Medicaid (referred to as Medi-Cal in California) Program, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs.

24. **Department of Managed Health Care (DMHC)** means the State agency responsible for administering the Knox-Keene Health Care Service Plan Act of 1975.

25. **Department of Mental Health (DMH)** means the State agency, in consultation with the California Mental Health Directors Association (CMHDA) and California Mental Health Planning Council, which sets policy and administers for the delivery of community based public mental health services statewide.

26. **Diagnosis of AIDS** means a clinical diagnosis of AIDS that meets the most recent communicable disease surveillance case definition of AIDS established by the federal Centers for Disease Control and Prevention (CDC), United States Department of Health and Human Services, and published in the Morbidity and Mortality Weekly Report (MMWR) or its supplements, in effect for the month in which the clinical diagnosis is made.

27. **Dietitian/Nutritionist** means a person who is registered or eligible for registration as a Registered Dietitian by the Commission on Dietetic Registration (Business and Professions Code, Chapter 5.65, Sections 2585 and 2586).

28. **Director** means the Director of the State of California Department of Health Services.

Exhibit E
Definitions

Attachment 1

29. **Disproportionate Share Hospital (DSH)** means a health Facility licensed pursuant to Chapter 2, Division 2, Health and Safety Code, to provide acute inpatient hospital services, which is eligible to receive payment adjustments from the State pursuant to W&I Code, Section 14105.98.

30. **Eligible Beneficiary** means any Medi-Cal beneficiary who is residing in the Contractor's Service Area with one of the following aid codes:

CalWORKs/Public Assistance Family - aid codes 30, 32, 33, 35, 38, 39, 3A, 3C, 3E, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 3W, 40, 42, 47, 4F, 4G, 4M, 54, 59, 5X, 72, 7X, 8P;

Medically Needy Family – aid code 34;

Public Assistance Aged – aid codes 1H, 10,16,18;

Medically Needy Aged – aid codes 1E, 14;

Public Assistance Blind – aid codes 20, 26, 28;

Medically Needy Blind – aid codes 2E, 24;

Public Assistance Disabled – aid codes 36, 60, 66, 68, 6A, 6C, 6H, 6J, 6N, 6P, 6R, 6V;

Medically Needy Disabled – aid code 6E, 64;

Medically Indigent Child – 03, 04, 4A, 4C, 4K, 45, 5K, 7A, 7J, 82, 8R;

Medically Indigent Adult – aid code 86;

Refugees – aid codes 01, 0A, 02, 08; and

Breast and Cervical Cancer Treatment Program (BCCTP) – aid codes 0M, 0N, 0P, 0R, 0T, and 0U.

Effective February 1, 2002, an Eligible Beneficiary may continue to be a Member following any redetermination of Medi-Cal eligibility that determines that the individual is eligible for, and the individual thereafter enrolls in, the BCCTP.

The following exclusions apply to all the above:

A. Individuals who have been approved by the Medi-Cal Field Office or the California Children Services Program for any major organ transplant that is a Medi-Cal FFS benefit except kidney transplants.

B. Individuals who elect and are accepted to participate in the following Medi-Cal waiver programs: In-Home Medical Care Waiver, the Nursing Facility Subacute Waiver, and the Nursing Facility Waiver.

C. Individual determined by the Medi-Cal Field Office to be in need of long term care and residing in a Skilled Nursing Facility for 30 days past the month of admission.

Exhibit E
Definitions

Attachment 1

D. Individuals who have commercial or Medicare HMO coverage, unless the Medicare HMO is a provider under this Contract and DHS has agreed, as a term of the HMO's contract, that these individuals may be enrolled. Individuals with Medicare fee-for-service coverage are not excluded from enrolling under this Contract.

31. **Emergency Medical Condition** means a medical condition which is manifested by acute symptoms of sufficient severity (including severe pain), such that a prudent lay person, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

A. Placing the health of the individual (or, in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

B. Serious impairment to bodily function, or

C. Serious dysfunction of any bodily organ or part.

32. **Emergency Services** means those health services needed to evaluate or stabilize an Emergency Medical Condition.

33. **Encounter** means any single medically related service rendered by (a) medical provider(s) to a Member enrolled in the health plan during the date of service. It includes, but is not limited to, all services for which the Contractor incurred any financial liability.

34. **Enrollment** means the process by which an Eligible Beneficiary becomes a Member of the Contractor's plan.

35. **External Accountability Set (EAS)** means a set of HEDIS® and DHS-developed performance measures selected by DHS for evaluation of health plan performance.

36. **External Quality Review Organization (EQRO)** means a Peer Review Organization (PRO), PRO-like entity, or accrediting body that is an expert in the scientific review of the quality of health care provided to Medicaid beneficiaries in a state's Medicaid managed care plans.

37. **Facility** means any premise that is:

A. Owned, leased, used or operated directly or indirectly by or for the Contractor or its Affiliates for purposes related to this Contract or

B. Maintained by a provider to provide services on behalf of the Contractor.

38. **Federal Financial Participation** means federal expenditures provided to match proper State expenditures made under approved State Medicaid plans.

39. **Federally Qualified Health Center (FQHC)** means an entity defined in Section 1905 of the Social Security Act (42 United States Code Section 1396d(l)(2)(B)).

40. **Federally Qualified Health Maintenance Organization (FQHMO)** means a prepaid health delivery plan that has fulfilled the requirements of the HMO Act, along with its amendments and regulations, and has obtained the Federal Government's qualification status under Section 1310(d) of the Public Health Service Act (42 USC §300e).

41. **Fee-For-Service (FFS)** means a method of payment based upon per unit or per procedure billing for services rendered to an Eligible Beneficiary.

42. **Fee-For-Service Medi-Cal** means the component of the Medi-Cal Program which Medi-Cal providers are paid directly by the State for services not covered under this Contract.

43. **Fee-For-Service Medi-Cal Mental Health Services (FFS/MC)** means the services covered through Fee-For-Service Medi-Cal which includes mental health outpatient services and acute care inpatient services.

44. **Financial Performance Guarantee** means cash or cash equivalents which are immediately redeemable upon demand by DHS, in an amount determined by DHS, which shall not be less than one full month's capitation.

45. **Financial Statements** means the Financial Statements which include a Balance Sheet, Income Statement, Statement of Cash Flows, Statement of Equity and accompanying footnotes prepared in accordance with Generally Accepted Accounting Principles.

46. **Fiscal Year (FY)** means any 12-month period for which annual accounts are kept. The State Fiscal Year is July 1 through June 30, the federal Fiscal Year is October 1 through September 30.

47. **Health Maintenance Organization (HMO)** means an organization that is not a federally qualified HMO, but meets the State Plan's definition of an HMO including the requirements under Section 1903(m)(2)(A)(i-vii) of the Social Security Act. An Organization that, through a coordinated system of health care, provides or assures the delivery of an agreed upon set of comprehensive health

maintenance and treatment services for an enrolled group of persons through a predetermined periodic fixed prepayment.

48. **Health Plan Employer Data and Information Set (HEDIS®)** means the set of standardized performance measures sponsored and maintained by the National Committee for Quality Assurance.

49. **HEDIS® Compliance Audit** means an audit process that uses specific standards and guidelines for assessing the collection, storage, analysis, and reporting of HEDIS® measures. This audit process is designed to ensure accurate HEDIS® reporting.

50. **Indian Health Service (IHS) Facilities** means Facilities operated with funds from the IHS under the Indian Self-Determination Act and the Indian Health Care Improvement Act, through which services are provided, directly or by contract, to the eligible Indian population within a defined geographic area. (See Title 22, Section 55000.)

51. **Intermediate Care Facility (ICF)** means a Facility which is licensed as an ICF by DHS or a hospital or Skilled Nursing Facility which meets the standards specified in Title 22, CCR, Section 51212 and has been certified by DHS for participation in the Medi-Cal program.

52. **Joint Commission on the Accreditation of Health Care Organizations (JCAHO)** means the organization composed of representatives of the American Hospital Association, the American Medical Association, the American College of Physicians, the American College of Surgeons, and the American Dental Association. JCAHO provides health care accreditation and related services that support performance improvement in health care organizations.

53. **Knox-Keene Health Care Service Plan Act of 1975** means the law that regulates HMOs and is administrated by the DMHC, commencing with Section 1340, Health & Safety Code.

54. **Marketing** means any activity conducted on behalf of the Contractor where information regarding the services offered by the Contractor is disseminated in order to persuade Eligible Beneficiaries to enroll. Marketing also includes any similar activity to secure the endorsement of any individual or organization on behalf of the Contractor.

55. **Marketing Representative** means a person who is engaged in marketing activities on behalf of the Contractor.

Exhibit E
Definitions

Attachment 1

56. **Medi-Cal Eligibility Data System (MEDS)** means the automated eligibility information processing system operated by the State which provides on-line access for recipient information, update of recipient eligibility data and on-line printing of immediate need beneficiary identification cards.

57. **Medical Records** means written documentary evidence of treatments rendered to plan Members.

58. **Medically Necessary** or **Medical Necessity** means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.

When determining the medical necessity of Covered Services for a Medi-Cal beneficiary under the age of 21, "medical necessity" is expanded to include the standards set forth in Title 22, CCR, Section 51340 and 51340.1.

59. **Member** means any Eligible Beneficiary who has enrolled in the Contractor's plan. For the purposes of this Contract, "Enrollee" shall have the same meaning as "Member".

60. **Member Grievance** means an oral or written expression of dissatisfaction, including any complaint, dispute, request for reconsideration or appeal made by a Member. DHS considers complaints and appeals the same as a grievance.

61. **Minimum Performance Level** refers to a minimum requirement of performance of Contractor on each of the External Accountability Set measures.

62. **Minor Consent Services** means those Covered Services of a sensitive nature which minors do not need parental consent to access, related to:

A. Sexual assault, including rape.

B. Drug or alcohol abuse for children 12 years of age or older.

C. Pregnancy.

D. Family planning.

E. Sexually transmitted diseases (STDs), designated by the Director, in children 12 years of age or older.

F. Outpatient mental health care for children 12 years of age or older who are mature enough to participate intelligently and where either (1) there is

a danger of serious physical or mental harm to the minor or others or (2) the children are the alleged victims of incest or child abuse.

63. **National Committee for Quality Assurance (NCQA)** is a non-profit organization committed to evaluating and publicly reporting on the quality of managed care plans.

64. **NCQA Licensed Audit Organization** is an entity licensed to provide auditors certified to conduct HEDIS Compliance Audits.

65. **Newborn Child** means a child born to a Member during her membership or the month prior to her membership.

66. **Non-Emergency Medical Transportation** means inclusion of services outlined in Title 22, CCR, Sections 51231.1 and 51231.2 rendered by licensed providers.

67. **Non-Medical Transportation** means transportation of Members to medical services by passenger car, taxicabs, or other forms of public or private conveyances provided by persons **not** registered as Medi-Cal providers. Does not include the transportation of sick, injured, invalid, convalescent, infirm, or otherwise incapacitated Members by ambulances, litter vans, or wheelchair vans licensed, operated and equipped in accordance with state and local statutes, ordinances or regulations.

68. **Non-Physician Medical Practitioners (Mid-Level Practitioner)** means a nurse practitioner, certified nurse midwife, or physician assistant authorized to provide Primary Care under Physician supervision.

69. **Not Reported** means: 1) Contractor calculated the measure but the result was materially biased; 2) Contractor did not calculate the measure even though a population existed for which the measure could have been calculated; and/or, 3) Contractor calculated the measure but chose not to report the rate.

70. **Nurse** means a person licensed by the California Board of Nursing as, at least, a Registered Nurse (RN).

71. **Other Healthcare Coverage Sources** (OHCS) means the responsibility of an individual or entity, other than Contractor or the Member, for the payment of the reasonable value of all or part of the healthcare benefits provided to a Member. Such OHCS may originate under any other State, federal or local medical care program or under other contractual or legal entitlement, including, but not limited to, a private group or indemnification program. This responsibility may result from a health insurance policy or other contractual agreement or legal obligation, excluding tort liability.

Exhibit E
Definitions

Attachment 1

72. **Outpatient Care** means treatment provided to a Member who is not confined in a health care Facility.

73. **Pediatric Subacute Care** means health care services needed by a person under 21 years of age who uses a medical technology that compensates for the loss of vital bodily function. Medical necessity criteria are described in the Physician's Manual of Criteria for Medi-Cal Authorization.

74. **Physician** means a person duly licensed as a Physician by the Medical Board of California.

75. **Physician Incentive Plan** means any compensation arrangement between Contractor and a Physician or a Physician group that may not directly or indirectly have the effect of reducing or limiting services provided to Members under this Contract.

76. **Policy Letter** means a document which has been dated, numbered and issued by the Medi-Cal Managed Care Division. It clarifies regulatory or contractual requirements.

77. **Post-Payment Recovery** means Contractor pays the provider for the services rendered and then uses all reasonable efforts to recover the cost of the services from all liable third parties.

78. **Potential Enrollee** means a Medi-Cal recipient who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program, but is not yet an enrollee of a specific plan."

79. **Preventive Care** means health care designed to prevent disease and /or its consequences.

80. **Primary Care** means a basic level of health care usually rendered in ambulatory settings by general practitioners, family practitioners, internists, obstetricians, pediatricians, and mid-level practitioners. This type of care emphasizes caring for the Member's general health needs as opposed to specialists focusing on specific needs.

81. **Primary Care Physician (PCP)** means a Physician responsible for supervising, coordinating, and providing initial and Primary Care to patients and serves as the medical home for Members. The medical home is where care is accessible, continuous, comprehensive, and culturally competent. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN).

Exhibit E
Definitions

Attachment 1

82. **Primary Care Provider** means a person responsible for supervising, coordinating, and providing initial and Primary Care to patients; for initiating referrals; and, for maintaining the continuity of patient care. A Primary Care Provider may be a Primary Care Physician or Non-Physician Medical Practitioner.

83. **Prior Authorization** means a formal process requiring a health care provider to obtain advance approval to provide specific services or procedures.

84. **Provider Grievance** means an oral or written expression of dissatisfaction, including any complaint, dispute, request for reconsideration or appeal made by a Provider. DHS considers complaints and appeals the same as a grievance.

85. **Quality Improvement (QI)** means the result of an effective Quality Improvement System.

86. **Quality Improvement Projects (QIPs)** means studies selected by Medi-Cal Managed Care Plans, either independently or in collaboration with DHS and other participating health plans, to be used for quality improvement purposes. The studies include four phases and may occur within a twenty-four (24) month time frame.

87. **Quality Improvement System (QIS)** means the systematic activities to monitor and evaluate the medical care delivered to Members according to the standards set forth in regulations and Contract language. Contractor must have processes in place, which measure the effectiveness of care, identify problems, and implement improvement on a continuing basis.

88. **Quality of Care** means the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

89. **Quality Indicators** means measurable variables relating to a specific clinic or health services delivery area which are reviewed over a period of time to screen delivered health care and to monitor the process or outcome of care delivered in that clinical area.

90. **Rural Health Clinic (RHC)** means an entity defined in Title 22, CCR, Section 51115.5.

91. **Safety-Net Provider** means any provider of comprehensive primary care or acute hospital inpatient services that provides these services to a significant total number of Medi-Cal and charity and/or medically indigent patients in relation to

the total number of patients served by the provider. Examples of safety net providers include Federally Qualified Health Centers; governmentally operated health systems; community health centers; rural and Indian Health Service Facilities; disproportionate share hospitals; and, public, university, rural, and children's hospitals.

92. **Service Area** means the county or counties that the Contractor is approved to operate in under the terms of this Contract. A Service Area may have designated ZIP Codes (under the U.S. Postal Service) within a county that are approved by DHS to operate under the terms of this Contract.

93. **Service Location** means any location at which a Member obtains any health care service provided by the Contractor under the terms of this Contract.

94. **Skilled Nursing Facility (SNF)** means, as defined in Title 22, CCR, Section 51121(a), any institution, place, building, or agency which is licensed as a SNF by DHS or is a distinct part or unit of a hospital, meets the standard specified in Section 51215 of these regulations (except that the distinct part of a hospital does not need to be licensed as a SNF) and has been certified by DHS for participation as a SNF in the Medi-Cal program. Section 51121(b) further defines the term "Skilled Nursing Facility" as including terms "skilled nursing home", "convalescent hospital", "nursing home", or "nursing Facility".

95. **Specialty Mental Health Provider** means a person or entity who is licensed, certified or otherwise recognized or authorized under State law governing the healing arts to provide Specialty Mental Health Services and who meets the standards for participation in the Medi-Cal program.

96. **Specialty Mental Health Service** means:

A. Rehabilitative services, which includes mental health services, medication support services, day treatment intensive, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services, and psychiatric health facility services;

B. Psychiatric inpatient hospital services;

C. Targeted Case Management;

D. Psychiatrist services;

E. Psychologist services; and,

F. EPSDT supplemental specialty mental health services.

Exhibit E
Definitions

Attachment 1

97. **State** means the State of California.

98. **State Supported Services** means those services that are provided under a different contract between the Contractor and the Department.

99. **Subacute Care** means, as defined in Title 22, CCR, Section 51124.5, a level of care needed by a patient who does not require hospital acute care but who requires more intensive licensed skilled nursing care than is provided to the majority of patients in a SNF.

100. **Subcontract** means a written agreement entered into by the Contractor with any of the following:

A. A provider of health care services who agrees to furnish Covered Services to Members.

B. Any other organization or person(s) who agree(s) to perform any administrative function or service for the Contractor specifically related to fulfilling the Contractor's obligations to DHS under the terms of this Contract.

101. **Sub-Subcontractor** means any party to an agreement with a subcontractor descending from and subordinate to a Subcontract, which is entered into for the purpose of providing any goods or services connected with the obligations under this Contract.

102. **Supplemental Security Income (SSI)** means the program authorized by Title XVI of the Social Security Act for aged, blind, and disabled persons.

103. **Targeted Case Management (TCM)** means services which assist Medi-Cal Members within specified target groups to gain access to needed medical, social, educational and other services. In prescribed circumstances, TCM is available as a Medi-Cal benefit as a discrete service, as well as through State or local government entities and their contractors.

104. **Third Party Tort Liability (TPTL)** means the responsibility of an individual or entity other than Contractor or the Member for the payment of claims for injuries or trauma sustained by a Member. This responsibility may be contractual, a legal obligation, or as a result of, or the fault or negligence of, third parties (e.g., auto accidents or other personal injury casualty claims or Workers' Compensation appeals).

Exhibit E
Definitions

Attachment 1

105. **Traditional Provider** means any physician who has delivered services to Medi-Cal beneficiaries within the last six months either through FFS Medi-Cal or a Medi-Cal Managed Care plan. The term includes physician and hospital providers only, either profit or non-profit entities, publicly or non-publicly owned and operated.

106. **Urgent Care** means services required to prevent serious deterioration of health following the onset of an unforeseen condition or injury (i.e., sore throats, fever, minor lacerations, and some broken bones).

107. **Utilization Review** means the process of evaluating the necessity, appropriateness, and efficiency of the use of medical services, procedures and Facilities.

108. **Vaccines for Children (VFC) Program** means the federally funded program that provides free vaccines for eligible children (including all Medi-Cal eligible children age 18 or younger) and distributes immunization updates and related information to participating providers. Providers subcontracting with the Contractor are eligible to participate in this program.

Exhibit E
Program Terms and Conditions

Attachment 2

1. Governing Law

In addition to Exhibit C, provision 14. Governing Law, Contractor also agrees to the following:

A. If it is necessary to interpret this Contract, all applicable laws may be used as aids in interpreting the Contract. However, the parties agree that any such applicable laws shall not be interpreted to create contractual obligations upon DHS or Contractor, unless such applicable laws are expressly incorporated into this Contract in some section other than this provision, Governing Law. Except for provision 16. Sanctions, and provision 17. Liquidated Damages Provision, the parties agree that any remedies for DHS' or Contractor's non-compliance with laws not expressly incorporated into this Contract, or any covenants implied to be part of this Contract, shall not include money damages, but may include equitable remedies such as injunctive relief or specific performance. This Contract is the product of mutual negotiation, and if any ambiguities should arise in the interpretation of this Contract, both parties shall be deemed authors of this Contract.

B. Any provision of this Contract which is in conflict with current or future applicable Federal or State laws or regulations is hereby amended to conform to the provisions of those laws and regulations. Such amendment of the Contract shall be effective on the effective date of the statutes or regulations necessitating it, and shall be binding on the parties even though such amendment may not have been reduced to writing and formally agreed upon and executed by the parties.

Such amendment shall constitute grounds for termination of this Contract in accordance with the procedures and provisions of provision 14, paragraph C. Termination - Contractor. The parties shall be bound by the terms of the amendment until the effective date of the termination.

C. The final Balanced Budget Act of 1997 regulations are published in the Federal Register/ Volume 67, Number 115/ June 14, 2002, at 42 Code of Federal Regulations, Parts 400, 430, 431, 434, 435, 438, 440 and 447. Contractor shall be in compliance with the final Balance Budget Act of 1997 regulations by August 13, 2003.

D. Medi-Cal Managed Care Division (MMCD) Policy Letters - These documents will be utilized to notify the Contractor of clarifications made to the Medi-Cal Managed Care Program. These documents will include instructions to the Contractor regarding implementation. These

documents will also be used to initiate various ongoing changes required of the Contractor throughout the Contract, the performance of which falls within the Contract's agreed upon capitated rate.

2. Entire Agreement

This written Contract and any amendments shall constitute the entire agreement between the parties. No oral representations shall be binding on either party unless such representations are reduced to writing and made an amendment to the Contract.

3. Amendment Process

In addition to Exhibit C, provision 2. Amendment, Contractor also agrees to the following:

Should either party, during the life of this Contract, desire a change in this Contract, that change shall be proposed in writing to the other party. The other party shall acknowledge receipt of the proposal within 10 days of receipt of the proposal. The party proposing any such change shall have the right to withdraw the proposal any time prior to acceptance or rejection by the other party. Any proposal shall set forth an explanation of the reason and basis for the proposed change and the text of the desired amendment to this Contract which would provide for the change. If the proposal is accepted, this Contract shall be amended to provide for the change mutually agreed to by the parties on the condition that the amendment is approved by DHHS, and the State Department of Finance, if necessary.

4. Change Requirements

A. General Provisions

The parties recognize that during the life of this Contract, the Medi-Cal Managed Care program will be a dynamic program requiring numerous changes to its operations and that the scope and complexity of changes will vary widely over the life of the Contract. The parties agree that the development of a system which has the capability to implement such changes in an orderly and timely manner is of considerable importance.

B. Contractor's Obligation to Implement

The Contractor will make changes mandated by DHS. In the case of mandated changes in regulations, statutes, federal guidelines, or judicial

interpretation, DHS may direct the Contractor to immediately begin implementation of any change by issuing a change order. If DHS issues a change order, the Contractor will be obligated to implement the required changes while discussions relevant to any capitation rate adjustment, if applicable, are taking place.

DHS may, at any time, within the general scope of the Contract, by written notice, issue change orders to the Contract.

C. Moral or Religious Objections to Providing a Service

If the Contractor has a moral or religious objection to providing a service or referral for a service for which the Contractor is not responsible, during the term of this agreement, the Contractor shall notify the DHS in writing providing sufficient detail to establish the moral or religious grounds for the objection.

5. Delegation Of Authority

DHS intends to implement this Contract through a single administrator, called the "Contracting Officer". The Director of DHS will appoint the Contracting Officer. The Contracting Officer, on behalf of DHS, will make all determinations and take all actions as are appropriate under this Contract, subject to the limitations of applicable Federal and State laws and regulations. The Contracting Officer may delegate his/her authority to act to an authorized representative through written notice to the Contractor.

Contractor will designate a single administrator; hereafter called the "Contractor's Representative". The Contractor's Representative, on behalf of the Contractor, will make all determinations and take all actions as are appropriate to implement this Contract, subject to the limitations of the Contract, Federal and State laws and regulations. The Contractor's Representative may delegate his/her authority to act to an authorized representative through written notice to the Contracting Officer. The Contractor's Representative will be empowered to legally bind the Contractor to all agreements reached with DHS.

Contractor shall designate Contractor's Representative in writing and shall notify the Contracting Officer in accordance with Exhibit E, Attachment 2, provision 10. Notices.

Exhibit E
Program Terms and Conditions

Attachment 2

6. Authority of the State

Sole authority to establish, define, or determine the reasonableness, the necessity and level and scope of covered benefits under the Medi-Cal Managed Care program administered in this Contract or coverage for such benefits, or the eligibility of the beneficiaries or providers to participate in the Medi-Cal Managed Care Program reside with DHS.

Sole authority to establish or interpret policy and its application related to the above areas will reside with DHS.

The Contractor may not make any limitations, exclusions, or changes in benefits or benefit coverage; any changes in definition or interpretation of benefits; or any changes in the administration of the Contract related to the scope of benefits, allowable coverage for those benefits, or eligibility of beneficiaries or providers to participate in the program, without the express, written direction or approval of the Contracting Officer.

7. Fulfillment of Obligations

No covenant, condition, duty, obligation, or undertaking continued or made a part of this Contract will be waived except by written agreement of the parties hereto, and forbearance or indulgence in any other form or manner by either party in any regard whatsoever will not constitute a waiver of the covenant, condition, duty, obligation, or undertaking to be kept, performed or discharged by the party to which the same may apply; and, until performance or satisfaction of all covenants, conditions, duties, obligations, and undertakings is complete, the other party will have the right to invoke any remedy available under this Contract, or under law, notwithstanding such forbearance or indulgence.

8. Obtaining DHS Approval

Contractor shall obtain written approval from DHS, as provided in Exhibit E, Attachment 3, provision 5 Approval Process, prior to commencement of operation under this Contract.

DHS reserves the right to review and approve any changes to Contractor's protocols, policies, and procedures as specified in this Contract.

Exhibit E
Program Terms and Conditions

Attachment 2

9. Certifications

Contractor shall comply with certification requirements set forth in 42 CFR 438.604 and 42 CFR 438.606.

In addition to Exhibit C, provision 11. Certifications, Contractor also agrees to the following:

With respect to any report, invoice, record, papers, documents, books of account, or other Contract required data submitted, pursuant to the requirements of this Contract, the Contractor's Representative or his/her designee will certify, under penalty of perjury, that the report, invoice, record, papers, documents, books of account or other Contract required data is current, accurate, complete and in full compliance with legal and contractual requirements to the best of that individual's knowledge and belief, unless the requirement for such certification is expressly waived by DHS in writing.

10. Notices

All notices to be given under this Contract will be in writing and will be deemed to have been given when mailed to DHS or the Contractor:

State Department of Health Services
Medi-Cal Managed Care Division
P.O. Box 942732
Sacramento, CA 94234-7320
Attn: Contracting Officer

Contractor Name and Address
Attn: Contractor Representative

11. Term

The Contract will become effective April 2, 1996, and will continue in full force and effect through March 31, 2004 subject to the provisions of Exhibit B, provision 1. Budget Contingency Clause and Exhibit D(F), provision 9. Federal Contract Funds because the State has currently appropriated and available for encumbrance only funds to cover costs through June 30, 2004.

The term of the Contract consists of the following three periods: 1) The Implementation Period shall extend from April 2, 1996; 2) The Operations Period shall extend from October 2, 1996 to March 31, 2004, subject to the termination provisions of provision 14, Termination for Cause and Other Terminations, and provision 16, Sanctions, and subject to the limitation provisions of Exhibit B, provision 1, Budget Contingency Clause; and 3) The Phaseout Period shall extend for six (6) months from the end of the Operations Period, subject to

provision 13. Contract Extension, in which case the Phaseout Period shall apply to the six (6) month period beginning the first day after the end of the Operations Period, as extended.

The Operations Period will commence subject to DHS acceptance of the Contractor's readiness to begin the Operations Period.

12. Service Area

The Service Area covered under this Contract includes:

Riverside and San Bernardino Counties

All Contract provisions apply separately to each Service Area. This Contract may expire for some Service Areas and still remain in effect for others with each Service Area having its own Implementation, Operations, and Phaseout periods.

13. Contract Extension

DHS will have the exclusive option to extend the term of the Contract for any Service Area during the last twelve (12) months of the Contract, as determined by the original expiration date or by a new expiration date if an extension option has been exercised. DHS may invoke up to three (3) separate extensions of up to twelve months each. The Contractor will be given at least nine (9) months prior written notice of DHS' decision on whether or not it will exercise this option to extend the Contract for each Service Area.

Contractor will provide written notification to DHS of its intent to accept or reject the extension within five (5) State working days of the receipt of the notice from DHS.

14. Termination for Cause and Other Terminations

In addition to Exhibit C, provision 7. Termination for Cause, Contractor also agrees to the following:

A. Termination - State or Director

DHS may terminate performance of work under this Contract in whole, or in part, whenever for any reason DHS determines that the termination is in the best interest of the State.

1) Notification shall be given at least six (6) months prior to the effective date of termination, except in cases described below in paragraph B. Termination for Cause.

2) If DHS awards a new contract for one or more of the Service Areas to another Contractor during one of the amendment periods as described above in Provision 13. Contract Extension, DHS shall provide the Contractor written notification at least six (6) months prior to termination to allow for all Phaseout Requirements to be completed.

B. Termination for Cause

1) DHS shall terminate this Contract pursuant to the provisions of Welfare and Institutions Code, Section 14304(a) and Title 22, CCR, Section 53873.

2) DHS shall terminate this Contract in the event that: (1) the Secretary, DHHS, determines that the Contractor does not meet the requirements for participation in the Medicaid program, Title XIX of the Social Security Act (42 U.S. Code § 1396), or (2) the Department of Managed Health Care finds that the Contractor no longer qualifies for licensure under the Knox-Keene Health Care Service Plan Act (Health and Safety Code § 1340 et seq.) by giving written notice to the Contractor. The termination will be effectuated consistent with the provisions of Title 22, CCR, Section 53873. Notification will be given by DHS at least sixty (60) days prior to the effective date of termination.

3) In cases where the Director determines the health and welfare of Members is jeopardized by continuation of the Contract, the Contract will be immediately terminated. Notification will state the effective date of, and the reason for, the termination.

Except for termination pursuant to paragraph B, item 3) above, termination of the Contract shall be effective on the last day of the month in which the Secretary, DHHS, or the DMHC makes such determination, provided that DHS provides Contractor with at least 60 days notice of termination. The termination of this Contract shall be effective on the last day of the second full month from the date of the notice of termination. Contractor agrees that 60 days notice is reasonable. Termination under this section does not relieve Contractor of its obligations under provision 15. Phaseout Requirements shall be performed after Contract termination.

C. Termination - Contractor

If mutual agreement between DHS and Contractor cannot be attained on capitation rates for rate years subsequent to September 30, 1997, Contractor shall retain the right to terminate the Contract, no earlier than September 30,1998, by giving at least nine (9) months written notice to DHS to that effect. The effective date of any termination under this section shall be September 30.

Grounds under which Contractor may terminate this Contract are limited to: (1) Unwillingness to accept the capitation rates determined by DHS, or if DHS decides to negotiate rates, failure to reach mutual agreement on rates; or (2) When a change in contractual obligations is created by a State or Federal change in the Medi-Cal program, or a lawsuit, that substantially alters the financial assumptions and conditions under which the Contractor entered into this Contract, such that the Contractor can demonstrate to the satisfaction of DHS that it cannot remain financially solvent through the term of the Contract.

If Contractor invokes ground number 2, Contractor shall submit a detailed written financial analysis to DHS supporting its conclusions that it cannot remain financially solvent. At the request of DHS, Contractor shall submit or otherwise make conveniently available to DHS, all of Contractor's financial work papers, financial reports, financial books and other records, bank statements, computer records, and any other information required by DHS to evaluate Contractor's financial analysis.

DHS and Contractor may negotiate an earlier termination date if Contractor can demonstrate to the satisfaction of DHS that it cannot remain financially solvent until the termination date that would otherwise be established under this section. Termination under these circumstances shall not relieve Contractor from performing the Phaseout Requirements described in provision 15.

D. Termination of Obligations

All obligations to provide Covered Services under this Contract or Contract extension will automatically terminate on the date the Operations Period ends.

E. Notice to Members of Transfer of Care

At least sixty (60) days prior to the termination of the Contract, DHS will notify Members about their medical benefits and available options.

15. Phaseout Requirements

A. DHS shall retain the lesser of an amount equal to 10% of the last month's Service Area capitation payment or one million dollars ($1,000,000) for each Service Area unless provided otherwise by the Financial Performance Guarantee, from the capitation payment of the last month of the Operations Period for each Service Area until all activities required during the Phaseout Period for each Service Area are fully completed to the satisfaction of DHS, in its sole discretion.

If all Phaseout activities for each Service Area are completed by the end of the Phaseout Period, the withhold will be paid to the Contractor. If the Contractor fails to meet any requirement(s) by the end of the Phaseout Period for each Service Area, DHS will deduct the costs of the remaining activities from the withhold amount and continue to withhold payment until all activities are completed.

B. The objective of the Phaseout Period is to ensure that, at the termination of this Contract, the orderly transfer of necessary data and history records is made from the Contractor to DHS or to a successor Contractor.

Ninety (90) days prior to termination or expiration of this Contract and through the Phaseout Period for each Service Area, the Contractor shall assist DHS in the transition of Members, and in ensuring, to the extent possible, continuity of Member-Provider relationships. In doing this, the Contractor will make available to DHS copies of Medical Records, patient files, and any other pertinent information, including information maintained by any subcontractor, necessary for efficient case management of Members, as determined by the Director. In no circumstances will a Medi-Cal Member be billed for this activity.

C. Phaseout for this Contract will consist of the processing, payment and monetary reconciliation(s) necessary regarding claims for payment for Covered Services.

Phaseout for the Contract will consist of the completion of all financial and reporting obligations of the Contractor. The Contractor will remain liable for the processing and payment of invoices and other claims for payment

for Covered Services and other services provided to Members pursuant to this Contract prior to the expiration or termination. The Contractor will submit to DHS all reports required in Exhibit A, Attachment 17, Reports, for the period from the last submitted report through the expiration or termination date.

All data and information provided by the Contractor will be accompanied by letter, signed by the responsible authority, certifying, under penalty of perjury, to the accuracy and completeness of the materials supplied.

16. Sanctions

In addition to complying with sanctions and civil penalties taken pursuant to Welfare and Institutions Code Section 14304 and Title 22 of the California Code of Regulations, Section 53872, if required by DHS, Contractor shall ensure subcontractors cease specified activities which may include, but are not limited to, referrals, assignment of beneficiaries, and reporting, until DHS determines that Contractor is again in compliance.

A. In the event DHS finds Contractor non-compliant with any provisions of this Contract, applicable statutes or regulations, DHS may impose sanctions provided in Welfare and Institutions Code, Section 14304 and Title 22, CCR, Section 53872 as modified for purposes of this Contract. Title 22, CCR, Section 53872 is so modified as follows:

   1) Subsection (b)(1) is modified by replacing “Article 2” with “Article 6”

   2) Subsection (b)(2) is modified by replacing “Article 3” with “Article 7”

B. The requirements of Exhibit A, Attachment 4, regarding QIS are all Contract provisions which are not specifically governed by Chapter 4.1 (commencing with Section 53800) of Division 3 of Title 22, CCR. Therefore, sanctions for violations of the requirements of Exhibit A, Attachment 4, regarding QIS shall be governed by Subsection 53872(b)(4)

C. For purposes of Sanctions, good cause includes, but is not limited to, the following:

   1) Three repeated and uncorrected findings of serious deficiencies that have the potential to endanger patient care identified in the medical audits conducted by DHS.

2) In the case of Exhibit A, Attachment 4, the Contractor consistently fails to achieve the minimum performance levels, or receives a "Not Reported" designation on an External Accountability Set measure, after implementation of Corrective Actions.

D. Sanctions in the form of denial of payments provided for under the contract for new enrollees shall be taken, when and for long as, payment for those enrollees is denied by Centers for Medicare and Medicaid Services (CMS) under 42 CFR § 438.730.

17. Liquidated Damages Provisions

A. General

It is agreed by the State and Contractor that:

1) If Contractor does not provide or perform the requirements of this Contract or applicable laws and regulations, damage to the State shall result;

2) Proving such damages shall be costly, difficult, and time-consuming;

3) Should the State choose to impose liquidated damages, Contractor shall pay the State those damages for not providing or performing the specified requirements;

4) Additional damages may occur in specified areas by prolonged periods in which Contractor does not provide or perform requirements;

5) The damage figures listed below represent a good faith effort to quantify the range of harm that could reasonably be anticipated at the time of the making of the Contract;

6) DHS may, at its discretion, offset liquidated damages from capitation payments owed to Contractor;

7) Imposition of liquidated damages as specified in paragraphs B. Liquidated Damages for Violation of Contract Terms Regarding the Implementation Period, C. Liquidated Damages for Violation of Contract Terms or Regulations Regarding the Operations Period,

and D. Annual Medical Reviews, shall follow the administrative processes described below;

8) DHS shall provide Contractor with written notice specifying the Contractor requirement(s), contained in the Contract or as required by federal and State law or regulation, not provided or performed;

9) During the Implementation Period, Contractor shall submit or complete the outstanding requirement(s) specified in the written notice within five (5) State working days from the date of the notice, unless, subject to the Contracting Officer's written approval, Contractor submits a written request for an extension. The request must include the following: the requirement(s) requiring an extension; the reason for the delay; and the proposed date of the submission of the requirement.

10) During the Implementation Period, if Contractor has not performed or completed an Implementation Period requirement or secured an extension for the submission of the outstanding requirement, DHS may impose liquidated damages for the amount specified in paragraph B. Liquidated Damages for Violation of Contract Terms Regarding the Implementation Period.

11) During the Operations Period, Contractor shall demonstrate the provision or performance of Contractor's requirement(s) specified in the written notice within a thirty (30) calendar day Corrective Action period from the date of the notice, unless a request for an extension is submitted to the Contracting Officer, subject to DHS' approval, within five (5) days from the end of the Corrective Action period. If Contractor has not demonstrated the provision or performance of Contractor's requirement(s) specified in the written notice during the Corrective Action period, DHS may impose liquidated damages for each day the specified Contractor's requirement is not performed or provided for the amount specified in paragraph C. Liquidated Damages for Violation of Contract Terms or Regulations Regarding the Operations Period.

12) During the Operations Period, if Contractor has not performed or provided Contractor's requirement(s) specified in the written notice or secured the written approval for an extension, after thirty (30) days from the first day of the imposition of liquidated damages, DHS shall notify Contractor in writing of the increase of the liquidated damages to the amount specified in paragraph C.

Liquidated Damages for Violation of Contract Terms or Regulations Regarding the Operations Period.

Nothing in this provision shall be construed as relieving Contractor from performing any other Contract duty not listed herein, nor is the State's right to enforce or to seek other remedies for failure to perform any other Contract duty hereby diminished.

B. Liquidated Damages for Violation of Contract Terms Regarding the Implementation Period

DHS may impose liquidated damages of $5,000 per requirement specified in the written notice for each day of the delay in completion or submission of Implementation Period requirements beyond the periods defined in the Contract.

If DHS determines that a delay or other non-performance was caused in part by the State, DHS will reduce the liquidated damages proportionately.

C. Liquidated Damages for Violation of Contract Terms or Regulations Regarding the Operations Period

DHS may impose liquidated damages of $1,000 per Contractor requirement not performed or provided during the Operations Period. If after thirty (30) days or such longer period as DHS may allow, the Contractor has not demonstrated the provision or performance of the Contractor requirement specified in the written notice, DHS may issue a written notice that the liquidated damages will be increased to $2,000 per day per Contractor requirement until the Contractor requirement is performed or provided.

If DHS determines that delay of the Contractor requirement was caused in part by the State, DHS will reduce the liquidated damages proportionately.

D. Annual Medical Reviews

DHS may impose liquidated damages of not less than $10,000 and not to exceed $50,000 for each major deficiency determined during the annual medical review. If, after notice, Contractor does not correct the deficiency to the satisfaction of DHS within thirty (30) days, or longer if authorized by DHS in writing, DHS may impose an additional liquidated damages of $5,000 per day per major uncorrected deficiency as determined by DHS medical review staff.

If DHS determines that non-performance of the requirement was caused in part by the State, DHS will reduce the liquidated damages proportionately.

E. Conditions for Termination of Liquidated Damages

Except as waived by the Contracting Officer, no liquidated damages imposed on the Contractor will be terminated or suspended until the Contractor issues a written notice of correction to the Contracting Officer certifying, under penalty of perjury, the correction of condition(s) for which liquidated damages were imposed. Liquidated damages will cease on the day of the Contractor's certification only if subsequent verification of the correction by DHS establishes that the correction has been made in the manner and at the time certified to by the Contractor.

The Contracting Officer will determine whether the necessary level of documentation has been submitted to verify corrections. The Contracting Officer will be the sole judge of the sufficiency and accuracy of any documentation. Corrections must be sustained for a reasonable period of at least ninety (90) days from DHS acceptance; otherwise, liquidated damages may be reimposed without a succeeding grace period within which to correct. The Contractor's use of resources to correct deficiencies will not be allowed to cause other contract compliance problems.

F. Severability of Individual Liquidated Damages Clauses

If any portion of these liquidated damages provisions is determined to be unenforceable, the other portions will remain in full force and effect.

18. Disputes

In addition to Exhibit C, provision 6. Disputes, Contractor also agrees to the following:

This Disputes section will be used by the Contractor as the means of seeking resolution of disputes on contractual issues.

Filing a dispute will not preclude DHS from recouping the value of the amount in dispute from the Contractor or from offsetting this amount from subsequent capitation payment(s). If the amount to be recouped exceeds 25 percent of the capitation payment, amounts of up to 25 percent will be withheld from successive capitation payments until the amount in dispute is fully recouped.

Exhibit E
Program Terms and Conditions

Attachment 2

A. Disputes Resolution by Negotiation

DHS and Contractor agree to try to resolve all contractual issues by negotiation and mutual agreement at the Contracting Officer level without litigation. The parties recognize that the implementation of this policy depends on open-mindedness, and the need for both sides to present adequate supporting information on matters in question.

B. Notification of Dispute

Within fifteen (15) days of the date the dispute concerning performance of this Contract arises or otherwise becomes known to the Contractor, the Contractor will notify the Contracting Officer in writing of the dispute, describing the conduct (including actions, inactions, and written or oral communications) which it is disputing.

The Contractor's notification will state, on the basis of the most accurate information then available to the Contractor, the following:

1) That it is a dispute pursuant to this section.
2) The date, nature, and circumstances of the conduct which is subject of the dispute.
3) The names, phone numbers, function, and activity of each Contractor, Subcontractor, DHS/State official or employee involved in or knowledgeable about the conduct.
4) The identification of any documents and the substances of any oral communications involved in the conduct. Copies of all identified documents will be attached.
5) The reason the Contractor is disputing the conduct.
6) The cost impact to the Contractor directly attributable to the alleged conduct, if any.
7) The Contractor's desired remedy.

The required documentation, including cost impact data, will be carefully prepared and submitted with substantiating documentation by the

Contractor. This documentation will serve as the basis for any subsequent appeal.

Following submission of the required notification, with supporting documentation, the Contractor will comply with the requirements of Title 22, CCR, Section 53851 (d) and diligently continue performance of this Contract, including matters identified in the Notification of Dispute, to the maximum extent possible.

C. Contracting Officer's or Alternate Dispute Officer's Decision

Pursuant to a request by Contractor, the Contracting Officer may provide for a dispute to be decided by an alternate dispute officer designated by DHS, who is not the Contracting Officer and is not directly involved in the Medi-Cal Managed Care Program. Any disputes concerning performance of this Contract shall be decided by the Contracting Officer or the alternate dispute officer in a written decision stating the factual basis for the decision. Within thirty (30) days of receipt of a Notification of Dispute, the Contracting Officer or the alternate dispute officer, shall either:

1) Find in favor of Contractor, in which case the Contracting Officer or alternate dispute officer may:

   a) Countermand the earlier conduct which caused Contractor to file a dispute; or

   b) Reaffirm the conduct and, if there is a cost impact sufficient to constitute a change in obligations pursuant to the payment provisions contained in Exhibit B, direct DHS to comply with that Exhibit.

Or,

2) Deny Contractor's dispute and, where necessary, direct the manner of future performance; or

3) Request additional substantiating documentation in the event the information in Contractor's notification is inadequate to permit a decision to be made under 1) or 2) above, and shall advise Contractor as to what additional information is required, and establish how that information shall be furnished. Contractor shall have thirty (30) days to respond to the Contracting Officer's or alternate dispute officer's request for further information. Upon receipt of this additional requested information, the Contracting

Officer or alternate dispute officer shall have thirty (30) days to respond with a decision. Failure to supply additional information required by the Contracting Officer or alternate dispute officer within the time period specified above shall constitute waiver by Contractor of all claims in accordance with item F. Waiver of Claims.

A copy of the decision shall be served on Contractor.

D. Appeal of Contracting Officer's or Alternate Dispute Officer's Decision

Contractor shall have thirty (30) calendar days following the receipt of the decision to file an appeal of the decision to the Director. All appeals shall be governed by Health and Safety Code Section 100171, except for those provisions of Section 100171(d)(1) relating to accusations, statements of issues, statement to respondent, and notice of defense. All appeals shall be in writing and shall be filed with DHS' Office of Administrative Hearings and Appeals. An appeal shall be deemed filed on the date it is received by the Office of Administrative Hearings and Appeals. An appeal shall specifically set forth each issue in dispute, and include Contractor's contentions as to those issues. However, Contractor's appeal shall be limited to those issues raised in its Notification of Dispute filed pursuant to paragraph B. Notification of Dispute. Failure to timely appeal the decision shall constitute a waiver by Contractor of all claims arising out of that conduct, in accordance with paragraph F. Waiver of Claims. Contractor shall exhaust all procedures provided for in this provision 18. Disputes, prior to initiating any other action to enforce this Contract.

E. Contractor Duty to Perform

Pending final determination of any dispute hereunder, Contractor shall comply with the requirements of Title 22, CCR, Section 53851 (d) and proceed diligently with the performance of this Contract and in accordance with the Contracting Officer's or alternate dispute officer's decision.

If pursuant to an appeal under paragraph D. Appeal of Contracting Officer's or Alternate Dispute Officer's Decision, the Contracting Officer's or alternate dispute officer's decision is reversed, the effect of the decision pursuant to paragraph D. shall be retroactive to the date of the Contracting Officer's or alternate dispute officer's decision, and Contractor shall promptly receive any benefits of such decision. DHS shall not pay interest on any amounts paid pursuant to a Contracting Officer's or alternate dispute officer's decision or any appeal of such decision.

F. Waiver of Claims

If Contractor fails to submit a Notification of Dispute, supporting and substantiating documentation, any additionally required information, or an appeal of the Contracting Officer's or alternate dispute officer's decision, in the manner and within the time specified in this provision 18. Disputes, that failure shall constitute a waiver by Contractor of all claims arising out of that conduct, whether direct or consequential in nature.

19. Audit

In addition to Exhibit C, provision 4. Audit, Contractor also agrees to the following:

The Contractor will maintain such books and records necessary to disclose how the Contractor discharged its obligations under this Contract. These books and records will disclose the quantity of Covered Services provided under this Contract, the quality of those services, the manner and amount of payment made for those services, the persons eligible to receive Covered Services, the manner in which the Contractor administered its daily business, and the cost thereof.

A. Books and Records

These books and records will include, but are not limited to, all physical records originated or prepared pursuant to the performance under this Contract including working papers; reports submitted to DHS; financial records; all Medical Records, medical charts and prescription files; and other documentation pertaining to medical and non-medical services rendered to Members.

B. Records Retention

Notwithstanding any other records retention time period set forth in this Contract, these books and records will be maintained for a minimum of five years from the end of the Fiscal Year in which the Contract expires or is terminated, or, in the event the Contractor has been duly notified that DHS, DHHS, DOJ, or the Comptroller General of the United States, or their duly authorized representatives, have commenced an audit or investigation of the Contract, until such time as the matter under audit or investigation has been resolved, whichever is later.

Exhibit E
Program Terms and Conditions

Attachment 2

20. Inspection Rights

In addition to Exhibit D (F), provision 8, Site Inspection, Contractor also agrees to the following:

Through the end of the records retention period specified in provision 19, Audit, paragraph B. Records Retention, Contractor shall allow the DHS, Department of Health and Human Services, the Comptroller General of the United States, Department of Justice (DOJ) Bureau of Medi-Cal Fraud, DMHC, and other authorized State agencies, or their duly authorized representatives, including DHS' external quality review organization contractor, to inspect, monitor or otherwise evaluate the quality, appropriateness, and timeliness of services performed under this Contract, and to inspect, evaluate, and audit any and all books, records, and Facilities maintained by Contractor and subcontractors pertaining to these services at any time during normal business hours.

Books and records include, but are not limited to, all physical records originated or prepared pursuant to the performance under this Contract, including working papers, reports, financial records, and books of account, Medical Records, prescription files, laboratory results, Subcontracts, information systems and procedures, and any other documentation pertaining to medical and non-medical services rendered to Members. Upon request, through the end of the records retention period specified in provision 19, Audit, paragraph B. Records Retention, Contractor shall furnish any record, or copy of it, to DHS or any other entity listed in this section, at Contractor's sole expense.

A. Facility Inspections

DHS shall conduct unannounced validation reviews on a number of the Contractor's Primary Care sites, selected at DHS' discretion, to verify compliance of these sites with DHS requirements.

B. Access Requirements and State's Right To Monitor

Authorized State and Federal agencies will have the right to monitor all aspects of the Contractor's operation for compliance with the provisions of this Contract and applicable federal and State laws and regulations. Such monitoring activities will include, but are not limited to, inspection and auditing of Contractor, subcontractor, and provider facilities, management systems and procedures, and books and records as the Director deems appropriate, at anytime during the Contractor's or other facility's normal business hours. The monitoring activities will be either announced or unannounced.

To assure compliance with the Contract and for any other reasonable purpose, the State and its authorized representatives and designees will have the right to premises access, with or without notice to the Contractor. This will include the MIS operations site or such other place where duties under the Contract are being performed.

Staff designated by authorized State agencies will have access to all security areas and the Contractor will provide, and will require any and all of its subcontractors to provide, reasonable facilities, cooperation and assistance to State representative(s) in the performance of their duties. Access will be undertaken in such a manner as to not unduly delay the work of the Contractor and/or the subcontractor(s).

21. Confidentiality of Information

In addition to Exhibit D (F), provision 13. Confidentiality of Information, Contractor also agrees to the following duties and responsibilities with respect to confidentiality of information and data:

A. Notwithstanding any other provision of this Contract, names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with Title 42, CFR, Section 431.300 et seq., Section 14100.2, W&I Code, and regulations adopted thereunder. For the purpose of this Contract, all information, records, data, and data elements collected and maintained for the operation of the Contract and pertaining to Members shall be protected by the Contractor from unauthorized disclosure.

Contractor may release Medical Records in accordance with applicable law pertaining to the release of this type of information. Contractor is not required to report requests for Medical Records made in accordance with applicable law.

B. With respect to any identifiable information concerning a Member under this Contract that is obtained by the Contractor or its subcontractors, the Contractor: (1) will not use any such information for any purpose other than carrying out the express terms of this Contract, (2) will promptly transmit to DHS all requests for disclosure of such information, except requests for Medical Records in accordance with applicable law, (3) will not disclose except as otherwise specifically permitted by this Contract, any such information to any party other than DHS without DHS' prior written authorization specifying that the information is releasable under

Title 42, CFR, Section 431.300 et seq., Section 14100.2, W&I Code, and regulations adopted thereunder, and (4) will, at the termination of this Contract, return all such information to DHS or maintain such information according to written procedures sent to the Contractor by DHS for this purpose.

22. Pilot Projects

DHS may establish pilot projects to test alternative managed care models tailored to suit the needs of populations with special health care needs. The operation of these pilot projects may result in the disenrollment of Members that participate. Implementation of a pilot project may affect the Contractor's obligations under this Contract. Any changes in the obligations of the Contractor that are necessary for the operation of a pilot project in the Contractor's Service Area will be implemented through a Contract amendment.

23. Cost Avoidance and Post-Payment Recovery of Other Health Coverage Sources (OHCS)

A. Contractor shall Cost Avoid or make a Post-Payment Recovery for the reasonable value of services paid for by Contractor and rendered to a Member whenever a Member's OHCS covers the same services, either fully or partially. However, in no event shall Contractor Cost Avoid or seek Post-Payment Recovery for the reasonable value of services from a Third-Party Tort Liability (TPTL) action or make a claim against the estates of deceased Members.

B. Contractor retains all monies recovered by Contractor.

C. Contractor shall coordinate benefits with other coverage programs or entitlements, recognizing the OHCS as primary and the Medi-Cal program as the payor of last resort.

D. Cost Avoidance

1) If Contractor reimburses the provider on a fee-for-service basis, Contractor shall not pay claims for services provided to a Member whose Medi-Cal eligibility record indicates third party coverage, designated by a Other Health Coverage (OHC) code or Medicare coverage, without proof that the provider has first exhausted all sources of other payments. Contractor shall have written procedures implementing this requirement.

2) Proof of third party billing is not required prior to payment for services provided to Members with OHC codes A, M, X, Y, or Z.

E. Post-Payment Recovery

1) If Contractor reimburses the provider on a fee-for-service basis, Contractor shall pay the provider's claim and then seek to recover the cost of the claim by billing the liable third parties:

a) For services provided to Members with OHC codes A, M, X, Y, or Z;

b) For services defined by DHS as prenatal or preventive pediatric services; or

c) In child-support enforcement cases, identifiable by Contractor. If Contractor does not have access to sufficient information to determine whether or not the OHC coverage is the result of a child enforcement case, Contractor shall follow the procedures for Cost Avoidance.

2) In instances where Contractor does not reimburse the provider on a fee-for-service basis, Contractor shall pay for services provided to a Member whose eligibility record indicates third party coverage, designated by a OHC code or Medicare coverage, and then shall bill the liable third parties for the cost of actual services rendered.

3) Contractor shall also bill the liable third parties for the cost of services provided to Members who are retroactively identified by Contractor or DHS as having OHC.

4) Contractor shall have written procedures implementing the above requirements.

F. Reporting Requirements

1) Contractor shall submit monthly reports to DHS, in a format prescribed by DHS, displaying claims counts and dollar amounts of costs avoided and the amount of Post-Payment Recoveries, by aid category, as well as the amount of outstanding recovery claims (accounts receivable) by age of account. The report shall display separate claim counts and dollar amounts for Medicare Part A and Part B. Reports shall be sent to the Department of Health Services,

Third Party Liability Branch, Cost Avoidance Unit, P.O. Box 2471, Sacramento, CA 95812-2471.

2) When Contractor identifies OHC unknown to DHS, Contractor shall report this information to DHS within ten (10) days of discovery in automated format as prescribed by DHS. This information shall be sent to the Department of Health Services, Third Party Liability Branch, Health Identification Unit, P.O. Box 2471, Sacramento, CA 95812-2471.

3) Contractor shall demonstrate to DHS that where Contractor does not Cost Avoid or perform Post-Payment Recovery that the aggregate cost of this activity exceeds the total revenues Contractor projects it would receive from such activity.

24. Third-Party Tort Liability

Contractor shall identify and notify DHS' Third Party Liability Branch of all instances or cases in which Contractor believes an action by the Medi-Cal Member involving casualty insurance or tort or Workers' Compensation liability of a third party could result in recovery by the Member of funds to which DHS has lien rights under Article 3.5 (commencing with Section 14124.70), Part 3, Division 9, Welfare and Institutions Code. Contractor shall make no claim for recovery of the value of Covered Services rendered to a Member in such cases or instances and such case or instance shall be referred to DHS' Third Party Liability Branch within ten (10) days of discovery. To assist DHS in exercising its responsibility for such recoveries, Contractor shall meet the following requirements:

A. If DHS requests service information and/or copies of paid invoices/claims for Covered Services to an individual Member, Contractor shall deliver the requested information within thirty (30) days of the request. Service information includes subcontractor and out-of-plan provider data. The value of the Covered Services shall be calculated as the usual, customary and reasonable charge made to the general public for similar services or the amount paid to subcontracted providers or out-of-plan providers for similar services.

B. Information to be delivered shall contain the following data items:

1) Member name.

2) Full 14 digit Medi-Cal number.

3) Social Security Number.
4) Date of birth.
5) Contractor name.
6) Provider name (if different from Contractor).
7) Dates of service.
8) Diagnosis code and description of illness/injury.
9) Procedure code and/or description of services rendered.
10) Amount billed by a subcontractor or out-of-plan provider to Contractor (if applicable).
11) Amount paid by other health insurance to Contractor or subcontractor (if applicable).
12) Amounts and dates of claims paid by Contractor to subcontractor or out-of-plan provider (if applicable).
13) Date of denial and reasons for denial of claims (if applicable).
14) Date of death (if applicable).

C. Contractor shall identify to DHS' Third Party Liability Branch the name, address and telephone number of the person responsible for receiving and complying with requests for mandatory and/or optional at-risk service information.

D. If Contractor receives any requests from attorneys, insurers, or beneficiaries for copies of bills, Contractor shall refer the request to Third Party Liability Branch with the information contained in paragraph B above, and shall provide the name, address and telephone number of the requesting party.

E. Information submitted to DHS under this section shall be sent to Department of Health Services, Third Party Liability Branch, Recovery Section, P.O. Box 2471, Sacramento, CA 95812-2471.

25. Records Related To Recovery For Litigation

A. Records

Upon request by DHS, Contractor shall timely gather, preserve and provide to DHS, in the form and manner specified by DHS, any information specified by DHS, subject to any lawful privileges, in Contractor's or its subcontractors' possession, relating to threatened or pending litigation by or against DHS. (If Contractor asserts that any requested documents are covered by a privilege, Contractor shall: 1) identify such privileged documents with sufficient particularity to reasonably identify the document while retaining the privilege; and 2) state the privilege being claimed that supports withholding production of the document.) Such request shall include, but is not limited to, a response to a request for documents submitted by any party in any litigation by or against DHS. Contractor acknowledges that time may be of the essence in responding to such request. Contractor shall use all reasonable efforts to immediately notify DHS of any subpoenas, document production requests, or requests for records, received by Contractor or its Subcontractors related to this Contract or subcontracts entered into under this Contract.

B. Payment for Records

In addition to the payments provided for in Exhibit B. Payment Provisions, DHS agrees to pay Contractor for complying with paragraph A, Records, above, as follows:

1) DHS shall reimburse Contractor amounts paid by Contractor to third parties for services necessary to comply with paragraph A. Any third party assisting Contractor with compliance with paragraph A above shall comply with all applicable confidentiality requirements. Amounts paid by Contractor to any third party for assisting Contractor in complying with paragraph A, shall not exceed normal and customary charges for similar services and such charges and supporting documentation shall be subject to review by DHS.

2) If Contractor uses existing personnel and resources to comply with paragraph A, DHS shall reimburse Contractor as specified below. Contractor shall maintain and provide to DHS time reports supporting the time spent by each employee as a condition of

reimbursement. Reimbursement claims and supporting documentation shall be subject to review by DHS.

a) Compensation and payroll taxes and benefits, on a prorated basis, for the employees' time devoted directly to compiling information pursuant to paragraph A.

b) Costs for copies of all documentation submitted to DHS pursuant to paragraph A, subject to a maximum reimbursement of ten (10) cents per copied page.

3) Contractor shall submit to DHS all information needed by DHS to determine reimbursement to Contractor under this provision, including, but not limited to, copies of invoices from third parties and payroll records.

26. Fraud and Abuse Reporting

Contractor shall meet requirements set forth in 42 CFR 438.608. Contractor shall report to the Contracting Officer all cases of suspected fraud and/or abuse, as defined in 42 Code of Federal Regulations, Section 455.2, where there is reason to believe that an incident of fraud and/or abuse has occurred, by subcontractors, Members, providers, or employees within ten (10) State working days of the date when Contractor first becomes aware of or is on notice of such activity. Contractor shall establish policies and procedures for identifying, investigating and taking appropriate corrective action against fraud and/or abuse in the provision of health care services under the Medi-Cal program. Contractor shall notify DHS prior to conducting any investigations, based upon Contractor's finding that there is reason to believe that an incident of fraud and/or abuse has occurred, and, upon the request of DHS, consult with DHS prior to conducting such investigations. Without waiving any privileges of Contractor, Contractor shall report investigation results within ten (10) State working days of conclusion of any fraud and/or abuse investigation.

27. Equal Opportunity Employer

Contractor will, in all solicitations or advertisements for employees placed by or on behalf of the Contractor, state that it is an equal opportunity employer, and will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding, a notice to be provided by DHS, advising the labor union or workers' representative of the Contractor's commitment as an equal opportunity employer and will post copies

of the notice in conspicuous places available to employees and applicants for employment.

28. Discrimination Prohibitions

A. Member Discrimination Prohibition

Contractor shall not discriminate against Members or Eligible Beneficiaries because of race, color, creed, religion, ancestry, marital status, sexual orientation, national origin, age, sex, or physical or mental handicap in accordance with Title VI of the Civil Rights Act of 1964, 42 USC Section 2000d, rules and regulations promulgated pursuant thereto, or as otherwise provided by law or regulations. For the purpose of this Contract, discriminations on the grounds of race, color, creed, religion, ancestry, age, sex, national origin, marital status, sexual orientation, or physical or mental handicap include, but are not limited to, the following:

1) Denying any Member any Covered Services or availability of a Facility;

2) Providing to a Member any Covered Service which is different, or is provided in a different manner or at a different time from that provided to other Members under this Contract except where medically indicated;

3) Subjecting a Member to segregation or separate treatment in any manner related to the receipt of any Covered Service;

4) Restricting a Member in anyway in the enjoyment of any advantage or privilege enjoyed by others receiving any Covered Service, treating a Member or Eligible Beneficiary differently from others in determining whether he or she satisfies any admission, Enrollment, quota, eligibility, membership, or other requirement or condition which individuals must meet in order to be provided any Covered Service;

5) The assignment of times or places for the provision of services on the basis of the race, color, creed, religion, age, sex, national origin, ancestry, marital status, sexual orientation, or the physical or mental handicap of the participants to be served.

Contractor shall take affirmative action to ensure that Members are provided Covered Services without regard to race, color, creed, religion,

sex, national origin, ancestry, marital status, sexual orientation, or physical or mental handicap, except where medically indicated.

For the purposes of this section, physical handicap includes the carrying of a gene which may, under some circumstances, be associated with disability in that person's offspring, but which causes no adverse effects on the carrier. Such genes will include, but are not limited to, Tay-Sachs trait, sickle cell trait, thalassemia trait, and X-linked hemophilia.

B. Discrimination Related To Health Status

Contractor shall not discriminate among eligible individuals on the basis of their health status requirements or requirements for health care services during enrollment, re-enrollment or disenrollment. Contractor will not terminate the enrollment of an eligible individual based on an adverse change in the Member's health.

C. Discrimination Complaints

Contractor agrees that copies of all grievances alleging discrimination against Members or Eligible Beneficiaries because of race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual orientation, or physical or mental handicap will be forwarded to DHS for review and appropriate action.

29. Americans With Disabilities Act Of 1990 Requirements

Contractor shall comply with all applicable federal requirements in Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990 (42 USC, Section 12101 et seq.), Title 45, Code of Federal Regulations (CFR), Part 84 and Title 28, CFR, Part 36. Title IX of the Education Amendments of 1972 (regarding education programs and activities), and the Age Discrimination Act of 1975.

30. Disabled Veteran Business Enterprises (DVBE)

Contractor shall comply with applicable requirements of California law relating to Disabled Veteran Business Enterprises (DVBE) commencing at Section 10115 of the Public Contract Code.

Exhibit E
Program Terms and Conditions

Attachment 2

31. Word Usage

Unless the context of this Contract clearly requires otherwise, (a) the plural and singular numbers shall each be deemed to include the other; (b) the masculine, feminine, and neuter genders shall each be deemed to include the others; (c) "shall," "will," "must," or "agrees" are mandatory, and "may" is permissive; (d) "or" is not exclusive; and (e) "includes" and "including" are not limiting.

32. Parties to State Fair Hearing

The parties to the State fair hearing include the Contractor as well as the Member and his or her representative or the representative of a deceased enrollee's estate.

Exhibit E
Duties of the State

Attachment 3

1. Payment For Services

DHS shall pay the appropriate capitation payments set forth in Exhibit B. Budget Detail and Payment Provisions, provision 4, to the Contractor for each eligible Member under this Contract, and ensure that such payments are reasonable and do not exceed the amount set forth in 42 CFR, Section 447.361. Payments will be made monthly for the duration of this Contract. Any adjustments for Federally Qualified Health Centers will be made in accordance with Section 14087.325 of the Welfare and Institutions Code.

2. Medical Reviews

DHS shall conduct medical reviews in accordance with the provisions of Section 14456, Welfare and Institutions Code. DHS shall have the discretion to accept plan performance reports, audits or reviews conducted by other agencies or accrediting bodies that use standards comparable to those of DHS. These plan performance reports, audits and reviews may be in lieu of an audit or review conducted by DHS in order to eliminate duplication of auditing efforts.

3. Enrollment Processing by DHS

A. General

The parties to this Contract agree that the primary purpose of DHS' Medi-Cal managed care system is to improve quality and access to care for Medi-Cal beneficiaries. The parties acknowledge that the Medi-Cal eligibility process and the managed care enrollment system are dynamic and complex programs. The parties also acknowledge that it is impractical to ensure that every beneficiary eligible for enrollment in the Contractor's plan will be enrolled in a timely manner. Furthermore, the parties recognize that for a variety of reasons some Eligible Beneficiaries will not be enrolled in Contractor's plan and will receive Covered Services in the Medi-Cal fee-for-service system. These reasons include, but are not limited to, the exclusion of some beneficiaries from participating in Medi-Cal managed care, the time it takes to enroll beneficiaries, and the lack of a current valid address for some beneficiaries. The parties desire to work together in a cooperative manner so that Eligible Beneficiaries who choose to or should be assigned to Contractor's plan are enrolled in Contractor's plan pursuant to the requirements of this entire provision 3. The parties agree that to accomplish this goal it is necessary to be reasonably flexible with regard to the enrollment process.

Exhibit E
Duties of the State

Attachment 3

B. Enrollment Processing Definitions

For purposes of this entire provision 3. Enrollment Processing by DHS, the following definitions shall apply:

1) Fully Converted County means a county in which the following circumstances exist, except for those Medi-Cal beneficiaries covered by Title 22, CCR, Section 53887:

   a) Eligible Beneficiaries who meet the mandatory enrollment criteria contained in Title 22, CCR, Section 53845(a) may no longer choose to receive Covered Services on a Fee-for-Service basis; and

   b) All new Eligible Beneficiaries who meet the mandatory enrollment criteria contained in Title 22, CCR, Section 53845(a) must now choose a managed care plan or they will be assigned to a managed care plan; and

   c) All Eligible Beneficiaries listed in the Medi-Cal Eligibility Data System (MEDS) as meeting the mandatory enrollment criteria contained in Title 22, CCR, Section 53845(a) on the last date that both a. and b. above occur:

      i. Have been notified of the requirement to choose a managed care plan and informed that if they fail to choose a plan they will be assigned to a managed care plan; and

      ii. Those beneficiaries still eligible for Medi-Cal and enrollment into a managed care plan at the time their plan enrollment is processed in MEDS have been enrolled into a managed care plan.

2) Mandatory Plan Beneficiary means:

   a) A new Eligible Beneficiary who meets the mandatory enrollment criteria contained in Title 22, CCR, Section 53845(a), both at the time her/his plan enrollment is processed by the DHS Enrollment Contractor and by MEDS; or

b) An Eligible Beneficiary previously receiving Covered Services in a county without mandatory managed care enrollment who now resides in a county where mandatory enrollment is in effect and who meets the mandatory enrollment criteria contained in Title 22, CCR, Section 53845(a); or

c) An Eligible Beneficiary meeting the criteria of Title 22, CCR, Section 53845(b), and who subsequently meets the criteria of Title 22, CCR, Section 53845(a).

3) Mandatory Plan Beneficiary shall not include any Eligible Beneficiary who:

a) is eligible to receive Covered Services on a Fee-for-Service basis because her/his MEDS eligibility for managed care plan enrollment is interrupted due to aid code, ZIP code or county code changes; or

b) becomes eligible for enrollment in a managed care plan on a retroactive basis.

C. DHS Enrollment Obligations

1) DHS shall receive applications for enrollment from its enrollment contractor and shall verify the current eligibility of applicants for enrollment in Contractor's plan under this Contract. If the Contractor has the capacity to accept new Members, DHS or its enrollment contractor shall enroll or assign Eligible Beneficiaries in Contractor's plan when selected by the Eligible Beneficiary or when the Eligible Beneficiary fails to timely select a plan. Of those to be enrolled or assigned in Contractor's plan, DHS will ensure that in a Fully Converted County a Mandatory Plan Beneficiary will receive an effective date of plan enrollment that is no later than 90 days from the date that MEDS lists such an individual as meeting the enrollment criteria contained in Title 22, CCR, Section 53845(a), if all changes to MEDS have been made to allow for the enrollment of the individual and all changes necessary to this Contract to accommodate such enrollment, including, but not limited to rate changes and aid code changes, have been executed. DHS will use due diligence in making any changes to MEDS and to this Contract. DHS will provide Contractor a list of Members on a monthly basis.

2) DHS or its enrollment contractor shall assign Eligible Beneficiaries meeting the enrollment criteria contained in Title 22, CCR, Section 53845(a) to plans in accordance with Title 22, CCR, Section 53884.

3) Notwithstanding any other provision in this Contract, subparagraphs 1) and 2) above shall not apply to:

a) Eligible Beneficiaries previously eligible to receive Medi-Cal services from a Prepaid Health Plan or Primary Care Case Management plan and such plan's contract with DHS expires, terminates, or is assigned or transferred to Contractor;

b) Members who are enrolled into another managed care plan on account of assignment, assumption, termination, or expiration of this Contract;

c) Eligible Beneficiaries covered by a new mandatory aid code, added to this Contract;

d) Eligible Beneficiaries meeting the criteria of Title 22, CCR, Section 53845(b), who subsequently meet the criteria of Title 22, CCR, Section 53845(a) due solely to DHS designating a prior voluntary aid code as a new mandatory aid code;

e) Eligible Beneficiaries residing in an excluded zip code area within a County that is not a fully Converted County; or

f) Eligible Beneficiaries without a current valid deliverable address or with an address designated as a County post office box for homeless beneficiaries.

D. Disputes Concerning DHS Enrollment Obligations

1) Contractor shall notify DHS of DHS' noncompliance with this provision 3. Enrollment Processing pursuant to the requirements and procedures contained in Exhibit E, Attachment 2, provision 18. Disputes.

2) DHS shall have 120 days from the date of DHS' receipt of Contractor's notice (the "cure period") to cure any noncompliance with this provision 3. Enrollment Processing, identified in Contractor's notice, without incurring any financial liability to the

Exhibit E
Duties of the State

Attachment 3

Contractor. For purposes of this section, DHS shall be deemed to have cured any noncompliance with this provision 3. Enrollment Processing, identified in Contractor's notice if within the cure period any of the following occurs:

a) Mandatory Plan Beneficiaries receive an effective date of plan enrollment that is within the cure period, or

b) DHS corrects enrollment that failed to comply with this provision 3. Enrollment Processing, by redirecting enrollment from one Contractor to another within the cure period in order to comply with this provision 3. Enrollment Processing, or

c) Within the cure period, DHS changes the distribution of beneficiary Assignment (subject to the requirements of Title 22, CCR, Section 53845(b)(1) through (b)(4)), to the maximum extent new beneficiaries are available to be assigned, to make up the number of incorrectly assigned beneficiaries as soon as possible.

3) If it is necessary to redirect enrollment or change the distribution of beneficiary Assignment due to noncompliance with this provision 3. Enrollment Processing, and such change varies from the requirements of Title 22, CCR, Section 53884(b)(5) or (b)(6), Contractor agrees it will neither seek legal nor equitable relief for such variance or the results of such variance if DHS resumes assignment consistent with Sections 53884(b)(5) or (b)(6) after correcting a noncompliance with this provision 3. Enrollment Processing.

4) Notwithstanding Exhibit E, Attachment 2, provision 1. Governing Law or any other provision of this Contract, if DHS fails to cure a noncompliance with this provision 3. Enrollment Processing, within the cure period, DHS will be financially liable for such noncompliance as follows:

DHS will be financially liable for Contractor's demonstrated actual reasonable losses as a result of the noncompliance, beginning with DHS' first failure to comply with its enrollment obligation set forth herein. DHS' financial liability shall not exceed 15 percent of Contractor's monthly capitation payment calculated as if noncompliance with this provision 3. Enrollment Processing did not

occur, for each month in which DHS has not cured noncompliance pursuant to paragraph D. subparagraph 2) above, beginning with DHS' first failure to comply with its enrollment obligation set forth herein.

5) Notwithstanding paragraph D. subparagraph 4) above, DHS shall not be financially liable to Contractor for any noncompliance with provision 3. Enrollment Processing, in an affected county (on a county-by-county basis) if Contractor's loss of Mandatory Plan Beneficiaries, in a month in which any noncompliance occurs, is less than five percent of Contractor's total Members in that affected county in the month in which the noncompliance occurs. The parties acknowledge that the above-referenced five-percent threshold shall apply on a county-by-county basis, not in the aggregate.

4. Disenrollment Processing

DHS shall review and process requests for Disenrollment and notify the Contractor and the Member of its decision.

5. DHS Approval Process

A. Within five (5) State working days of receipt, DHS shall acknowledge in writing the receipt of any material sent to DHS by Contractor pursuant to Exhibit E, Attachment 2, provision 8. Obtaining DHS Approval.

B. Within sixty (60) days of receipt, DHS shall make all reasonable efforts to approve in writing the use of such material provided to DHS pursuant to Exhibit E, Attachment 2, provision 8. Obtaining DHS Approval, provide Contractor with a written explanation why its use is not approved, or provide a written estimated date of completion of DHS' review process. If DHS does not complete its review of submitted material within sixty (60) days of receipt, or within the estimated date of completion of DHS review, Contractor may elect to implement or use the material at Contractor's sole risk and subject to possible subsequent disapproval by DHS. This paragraph shall not be construed to imply DHS approval of any material that has not received written DHS approval. This paragraph shall not apply to Subcontracts or sub-subcontracts subject to DHS approval in accordance with Exhibit A, Attachment 6, provision 13. Subcontracts, paragraph C. regarding Departmental Approval – Non-Federally Qualified HMOs, and paragraph D. regarding Departmental Approval – Federally Qualified HMOs.

Exhibit E
Duties of the State

Attachment 3

6. Program Information

DHS shall provide Contractor with complete and current information with respect to pertinent policies, procedures, and guidelines affecting the operation of this Contract, within thirty (30) days of receipt of Contractor's written request for information, to the extent that the information is readily available. If the requested information is not available, DHS shall notify Contractor within thirty (30) days, in writing, of the reason for the delay and when Contractor may expect the information.

7. Catastrophic Coverage Limitation

DHS shall limit the Contractor's liability to provide or arrange and pay for care for illness of, or injury to, Members which results from or is greatly aggravated by, a catastrophic occurrence or disaster.

8. Risk Limitation

DHS shall agree that there will be not risk limitation and that Contractor will have full financial liability to provide Medically Necessary Covered Services to Members.

9. Notice Of Termination Of Contract

DHS shall notify Members of their health care benefits and options available upon termination or expiration of this Contract.

Exhibit F

Contractor's Release

Instructions to Contractor:

With final invoice(s) submit one (1) original and two (2) copies. The original must bear the original signature of a person authorized to bind the Contractor. The additional copies may bear photocopied signatures.

Submission of Final Invoice

Pursuant to **contract number** _____ entered into between the State of California Department of Health Services (DHS) and the Contractor (identified below), the Contractor does acknowledge that final payment has been requested via **invoice number(s)** _____, in the **amount(s) of $** _____ and **dated** _____. If necessary, enter "See Attached" in the appropriate blocks and attach a list of invoice numbers, dollar amounts and invoice dates.

Release of all Obligations

By signing this form, and upon receipt of the amount specified in the invoice number(s) referenced above, the Contractor does hereby release and discharge the State, its officers, agents and employees of and from any and all liabilities, obligations, claims, and demands whatsoever arising from the above referenced contract.

Repayments Due to Audit Exceptions / Record Retention

By signing this form, Contractor acknowledges that expenses authorized for reimbursement does not guarantee final allowability of said expenses. Contractor agrees that the amount of any sustained audit exceptions resulting from any subsequent audit made after final payment, will be refunded to the State.

All expense and accounting records related to the above referenced contract must be maintained for audit purposes for no less than three years beyond the date of final payment, unless a longer term is stated in said contract.

Recycled Product Use Certification

By signing this form, Contractor certifies under penalty of perjury that a percentage (0% to 100%) of the materials, goods, supplies or products offered or used in the performance of the above referenced contract meets or exceeds the minimum percentage of recycled material, as defined in Public Contract Code Sections 12161 and 12200.

Reminder to Return State Equipment/Property (If Applicable)
(Applies only if equipment was provided by DHS or purchased with or reimbursed by contract funds)

Unless DHS has approved the continued use and possession of State equipment (as defined in the above referenced contract) for use in connection with another DHS agreement, Contractor agrees to promptly initiate arrangements to account for and return said equipment to DHS, at DHS's expense, if said equipment has not passed its useful life expectancy as defined in the above referenced contract.

Patents / Other Issues

By signing this form, Contractor further agrees, in connection with patent matters and with any claims that are not specifically released as set forth above, that it will comply with all of the provisions contained in the above referenced contract, including, but not limited to, those provisions relating to notification to the State and related to the defense or prosecution of litigation.

Contractors Legal Name (As on Contract): _____

Signature of Contractor or Official Designee: _____ Date: _____

Printed Name/Title of Person Signing: _____

DHS Distribution: Accounting(Original) Program CMU contract file

Exhibit G
Health Insurance Portability and Accountability Act (HIPAA)

1. Recitals

A. "Protected Health Information" or "PHI" means any information, whether oral or recorded in any form or medium that relates to the past, present, or future physical or mental condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual. PHI shall have the meaning given to such term under HIPAA and HIPAA regulations, as the same may be amended from time to time.

B. DHS desires to protect the privacy and provide for the security of PHI disclosed pursuant to this Contract.

IN THE USE OR DISCLOSURE OF INFORMATION PURSUANT TO THIS CONTRACT, THE PARTIES AGREE AS FOLLOWS:

2. Permitted Uses and Disclosures.

A. *Permitted Uses and Disclosures.* Except as otherwise required by law, Contractor may use or disclose PHI only to perform functions, activities or services specified in this Contract provided that such use or disclosure is for purposes directly connected with the administration of the Medi-Cal program. Those activities which are for purposes directly connected with the administration of the Medi-Cal program include, but are not limited to: establishing eligibility and methods of reimbursement; determining the amount of medical assistance; providing services for recipients; conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the administration of the Medi-Cal program; and conducting or assisting a legislative investigation or audit related to the administration of the Medi-Cal program.

B. *Specific Use and Disclosure Provisions.* Except as otherwise indicated in this Contract, Contractor may:

1) *Use and disclose for management and administration.* Use and disclose PHI for the proper management and administration of the Contractor or to carry out the legal responsibilities of the Contractor, provided that disclosures are required by law, or the Contractor obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and will be used or further disclosed only as required by law or for the purpose for which it was disclosed to the person, and the

Exhibit G
Health Insurance Portability and Accountability Act (HIPAA)

person notifies the Contractor of any instances of which it is aware that the confidentiality of the information has been breached.

2) *Provision of Data Aggregation Services.* Use PHI to provide data aggregation services to DHS. Data aggregation means the combining of PHI created or received by the Contractor on behalf of DHS with PHI received by the Contractor in its capacity as the Contractor of another covered entity, to permit data analyses that relate to the health care operations of DHS.

C. *Prohibition of External Disclosures of Lists of Beneficiaries.* A Contractor must provide DHS's contract manager with a list of external entities, including persons, organizations, and agencies, other than those within its treatment network and other than DHS, to which it discloses lists of Medi-Cal beneficiary names and addresses. This list must be provided within 30 days of the execution of this Contract and annually thereafter.

3. Responsibilities of Contractor.

Contractor agrees:

A. *Divulging Medi-Cal Status.* Not to divulge the Medi-Cal status of a Contractor's beneficiaries without DHS's prior approval except for treatment, payment and operations.

B. *Safeguards.* To implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the PHI, including electronic PHI, that it creates, receives, maintains or transmits on behalf of DHS; and to prevent use or disclosure of PHI other than as provided for by this Contract. Contractor shall maintain a comprehensive written information privacy and security program that includes administrative, technical and physical safeguards appropriate to the size and complexity of the Contractor's operations and the nature and scope of its activities. Contractor will provide DHS with information concerning such safeguards as DHS may reasonably request.

C. *Reporting of Improper Disclosures.* To report to the DHS contract manager within twenty-four (24) hours during a work week, of discovery by Contractor that PHI has been used or disclosed other than as provided for by this Contract or otherwise in violation of the HIPAA regulations or other statutes and regulations pertaining to privacy and security of PHI.

Exhibit G
Health Insurance Portability and Accountability Act (HIPAA)

D. *Contractor's Agents.* To ensure that any agents, including subcontractors but excluding providers of treatment services, to whom Contractor provides PHI received from or created or received by Contractor on behalf of DHS, agree to the same restrictions and conditions that apply to Contractor with respect to such PHI; and to incorporate, when applicable, the relevant provisions of this Contract into each subcontract or subaward to such agents or subcontractors.

E. *Availability of Information to Individuals.* To provide access to individuals (upon reasonable notice and during Contractor's normal business hours) to their PHI in a Designated Record Set in accordance with 45 CFR Section 164.524. Designated Record Set means the group of records maintained for DHS that includes medical and billing records about individuals; enrollment, payment, claims adjudication, and case or medical management systems maintained for DHS health plans; or those records used to make decisions about individuals on behalf of DHS.

F. *Internal Practices.* To make Contractor's internal practices, books and records relating to the use and disclosure of PHI received from DHS, or created or received by Contractor on behalf of DHS, available to DHS in a time and manner designated by DHS, for purposes of determining compliance with the provisions of this Exhibit.

G. *Documentation and Accounting of Disclosures.* To document and make available to DHS and to an Individual such disclosures of PHI, and information related to such disclosures, necessary to respond to a proper request by the subject Individual for an accounting of disclosures of PHI, in accordance with 45 CFR 164.528.

H. *Notification of Breach.* During the term of this Contract, to notify DHS within twenty-four (24) hours during a work week of any suspected or actual breach of security, intrusion or unauthorized use or disclosure of PHI and/or any actual or suspected use or disclosure of data in violation of any applicable Federal and State laws or regulations or this Exhibit. Contractor shall take (i) prompt corrective action to cure any such deficiencies and (ii) any action pertaining to such unauthorized disclosure required by applicable Federal and State laws and regulations. Contractor shall investigate such breach, or unauthorized use or disclosure of PHI, and provide a written report of the investigation to the DHS Privacy Officer within fifteen (15) working days of the discovery of the breach or unauthorized use at:

Exhibit G
Health Insurance Portability and Accountability Act (HIPAA)

Privacy Officer
c/o Office of Legal Services
California Department of Health Services
P.O. Box 942732
Sacramento, CA 94234-7320
(916) 255-5259

I. *Notice of Privacy Practices.* To produce a Notice of Privacy Practices (NPP) in accordance with standards and requirements of HIPAA, the HIPAA regulations, applicable State and Federal laws and regulations, and Section 2.A. of this Exhibit. Such NPP's must include the DHS Privacy Officer contact information included in part H. above of this Contract as an alternative means for Medi-Cal beneficiaries to lodge privacy complaints. All NPP's created or modified after August 1, 2003 must be submitted to the DHS contract manager for review.

4. Miscellaneous Provisions.

A. *Amendment.* The parties acknowledge that Federal and State laws relating to electronic data security and privacy are rapidly evolving and that amendment of this Contract may be required to provide for procedures to ensure compliance with such developments. The parties specifically agree to take such action as is necessary to implement the standards and requirements of HIPAA, the HIPAA regulations and other applicable laws relating to the security or privacy of PHI. Upon DHS's request, Contractor agrees to promptly enter into negotiations with DHS concerning an amendment to this Contract embodying written assurances consistent with the standards and requirements of HIPAA, the HIPAA regulations or other applicable laws. DHS may terminate this Contract upon thirty (30) days written notice in the event (i) Contractor does not promptly enter into negotiations to amend this Contract when requested by DHS pursuant to this Section or (ii) Contractor does not enter into an amendment providing assurances regarding the safeguarding of PHI that DHS in its sole discretion, deems sufficient to satisfy the standards and requirements of HIPAA, the HIPAA regulations, and applicable laws.

B. *Assistance in Litigation or Administrative Proceedings.* Contractor shall make itself and its employees, and use all due diligence to make any subcontractors or agents assisting Contractor in the performance of its obligations under this Contract, available to DHS at no cost to DHS to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against DHS, its directors, officers or employees based upon claimed violation of HIPAA, the HIPAA

Exhibit G
Health Insurance Portability and Accountability Act (HIPAA)

regulations or other laws relating to security and privacy, except where Contractor or its subcontractor, employee or agent is a named adverse party.

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. _____
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF VENDOR

TELEPHONE

VENDOR NUMBER/MAIL CODE

BUYER (517) 335-0230
Irene Pena

Contract Administrator: Cheryl Bupp
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
NA	**NA**
F.O.B.	SHIPPED FROM
NA	**NA**

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:**
Firm Name	Signature
Authorized Agent Signature	Name **State Purchasing Director**
Authorized Agent (Print or Type)	Title
Date	Date

TABLE OF CONTENTS
SECTION I

CONTRACTUAL SERVICES TERMS AND CONDITIONS

SECTION II

WORK STATEMENT

SECTION III

CONTRACTOR INFORMATION

APPENDICES

ATTACHMENTS

DEFINITIONS/EXPLANATION OF TERMS

Abuse	Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.
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.
Administrative Law Judge	A person designated by DCH to conduct the Administrative Hearing in an impartial or unbiased manner.
Advance directive	A written instruction, such as a living will or durable power of attorney for health care, recognized under State law, relating to the provision of health care when the individual is incapacitated.
Appeal	A request for review of a Contractor's decision that results in any of the following actions: • The denial or limited authorization of a requested service, including the type or level of service; • The reduction, suspension, or termination of a previously authorized service; • The denial, in whole or in part, of payment for a properly authorized and covered service; • The failure to provide services in a timely manner, as defined by the State; • The failure of a Contractor to act within the established timeframes for grievance and appeal disposition; • For a resident of a rural area with only one Medicaid Health Plan, the denial of a Medicaid enrollee's request to exercise his or her right, under 42 CFR 438.52(b)(2)(ii), to obtain services outside the network.
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	Clean Claim means that as defined in MCL 400.111i and the Michigan Office of Financial and Insurance Services Bulletin 2000/09.
CMHSP	Community Mental Health Services Program
CMS	Centers for Medicare and Medicaid Services
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, HMO, 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.
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. An Administrative Law Judge conducts the Administrative Hearing.
Department	The Department of Community Health and its 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, 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 who is currently enrolled in Medicaid managed care in a given Medicaid Health Plan.

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.
Expedited Appeal	An appeal conducted when the Contractor determines (based on the Enrollee request) or the provider indicates (in making the request on the enrollee's behalf or supporting the enrollee's request) that taking the time for a standard resolution could seriously jeopardize the Enrollee's life, health, or ability to attain, maintain, or regain maximum function.
Expedited Authorization Decision	An authorization decision required to be expedited due to a request by the provider or determination by the Contractor that following the standard timeframe could seriously jeopardize the Enrollee's life or health.
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
Fraud	An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.
Grievance	Grievance means an expression of dissatisfaction about any matter other than an action subject to appeal.
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.
HMO	An entity that has received and maintains a state license to operate as an HMO.
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.

Marketing	Marketing means any communication, from a Contractor directed to a Medicaid Beneficiary who is not enrolled in the Contractor's plan, that can reasonably be interpreted as intended to influence the Beneficiary to enroll in that particular Contractor's Medicaid product, or either to not enroll in, or to disenroll from, another health plan's Medicaid product.
Medicaid/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, or pediatric physician when appropriate for an Enrollee, other physician specialists when appropriate for an Enrollee's health condition, nurse practitioner, and physician assistants.
Persons with Special Health Care Needs	Enrollees who lose eligibility for the Children's Special Health Care Services (CSHCS) program due to the program's age requirements.
PMPM	Per Member Per Month.
Prevalent Language	Specific Non-English Language that is spoken as the primary language by more than 5% of the Contractor's Enrollees.
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.

Rural	Rural is defined as any county not included in a standard metropolitan area (SMA).
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.
Subcontractor	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.
Successful Bidder	The Bidder (Contractor) awarded a Contract as a result of a proposal submitted in response to the ITB.
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.

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 until October 1, 2004. The Contract may be extended for no more than one (1) one year extensions after September 30, 2004.

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:

Irene Pena
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:

Cheryl Bupp, Manager
Plan Management Section
Comprehensive Health Plan Division
Michigan Department of Community Health
P.O. Box 30479
Lansing, Michigan 48909-7979

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.

I-E PRICE

Price adjustments for the 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 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.

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 (CMS), 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;

(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.

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 there from, 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.

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.

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.

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

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.

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.

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.

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 (MHPs) include the implementation of local agreements with the behavioral health and developmental disability providers who are under 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. 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 CMS 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:

(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 same county.

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.

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
    - Pregnant women
2. Medicaid Eligible Groups Who May Voluntarily Enroll in the CHCP:
    - Migrants
    - Native Americans
    - Persons in the Traumatic Brain Injury program
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.

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;
- All such changes will be approved and implemented by DCH on a calendar month basis.

4. Rural Area Exception

The DCH will establish a Rural Exception Policy consistent with 42 CFR 438.52 and with the approval from The Centers for Medicare and Medicaid Services that permits a rural exception to the waiver requirement of having two HMOs in every county. This exception will permit mandatory enrollment of beneficiaries into a single health plan. This policy will only be implemented in counties that are designated as "Rural." A Rural County is defined as any county that is non-urban. The beneficiary much be permitted to choose from at least two physicians or case managers. The beneficiary must have the option of obtaining services from any other provider if the following conditions exist:

- The type of service or specialist is not available within the HMO,
- The provider is not part of the network, but is the main source of a service to the beneficiary,
- The only provider available to the beneficiary does not, because of moral or religious objections, provide the service the enrollee seeks,
- Related services must be performed by the same provider and all of the services are not available within network,
- The State determines other circumstances that warrant out of network treatment.

The State shall determine the rural counties to be part of this exception. The State will determine the method of Health Plan Selection and Payment based on Benchmark status, performance measures, provider network, current enrollment, and/or other factors relevant to the area. Attachment A (Awarded Price) will be amended, if applicable, if the health plan is awarded a rural exception county.

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. If the beneficiary resides in a county currently operating under the Rural Exception, there will be no open enrollment period.

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.
- 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 medically eligible for services under Title V of the Social Security Act as described in Section II-U-4-c*v* (page 56) 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. 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. Enrollees who are granted a disenrollment for cause will be required to change enrollment to another Contractor.

14. 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 disenrollments. DCH shall only retroactively enroll 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.

(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. 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 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.

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:

- Ambulance and other emergency medical transportation
- Blood lead follow-up services for individuals under the age of 21
- Certified nurse midwife services
- Certified pediatric and family nurse practitioner services
- Chiropractic services for persons under age 21
- Diagnostic lab, x-ray and other imaging services
- Durable medical equipment and supplies
- Emergency services
- End Stage Renal Disease services
- Family planning services
- Health education
- Hearing & speech services
- Hearing aids for persons under age 21
- Home Health services
- Hospice services (if requested by the Enrollee)
- Immunizations
- Inpatient and outpatient hospital services
- Intermittent or short-term restorative or rehabilitative nursing care (in or out of a facility)
- Maternal and Infant Support Services (MSS/ISS)
- Medically necessary weight reduction services
- Mental health care up to 20 outpatient visits per Contract year
- Out-of-state services authorized by the Contractor
- Outreach for included services, especially, pregnancy related and well-child care
- Parenting and birthing classes
- Pharmacy services
- Podiatry services for persons under age 21
- Practitioners' services (such as those provided by physicians, optometrists and dentists enrolled as a Medicaid Provider Type 10)
- Prosthetics & orthotics
- Therapies, (speech, language, physical, occupational)
- Transplant services
- Transportation
- Treatment for sexually transmitted disease (STD)
- Vision services
- Well child/EPSDT for persons under age 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 fee for participating in health education services that fall under the definition of a Covered Service under this 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

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 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;
- Certified providers must provide that maternal and infant support services.

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:

- 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.

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-

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, including, but not limited to, 42 CFR 447.50 through 447.60. 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.

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 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.

No provider may deny services to an individual who is eligible for the services due to the individual's inability to pay the co-payment.

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:

- 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.)

(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 an appropriate dental provider sees the child. 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.

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 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 credentialing and re-credentialing 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.

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 Bulletin (QHP 00-08). Services may be provided through contracts with Community Mental Health Services Programs (CMHSP) or through contracts with other appropriate providers within the service area.

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 CMS 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 CMS for the period April 22, 2003 through April 22, 2005. 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.

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 CMS Regulation

   Contractors are required to comply with all CMS regulations, including, but not limited to, the following:

   - Enrollee Payments: As required by 42 CFR Part 432.22, DCH will deny payment for new Enrollees when payment for those Enrollees are denied by CMS pursuant to 42 CFR 434.67(e).
   - Enrollment and Disenrollment: As required by 42 CFR 438.56, Contractors must meet all the requirements specified for enrollment and disenrollment limitations.
   - Provision of Covered Services: As required by 42 CFR 438.102(2), Contractors are required to provide all covered services listed in Section II-H or II-I of the contract.

6. Compliance with HIPAA Regulation

   The Contractor shall comply with all applicable provisions of the Health Insurance Portability and Accountability Act of 1996 by the required deadlines (codified at 45 CFR Parts 160 through 164).

7. Advanced Directives Compliance

   The Contractor shall comply with all provisions for advance directives as required under 42 CFR 434.28. The Contractor must have in effect, written policies and procedures for the use and handling of advance directives written for any adult individual receiving medical care by or through the Contractor. The policies and procedures must include at least the following provisions:

   - The Enrollees' right to have and exercise advance directives under the law of the State of Michigan, [MCL 700.5506-700.5512 (Act 386 of 1998) and MCL 333.1051-333.1064 (Act 193 of 1996)]. Changes to State law must be updated in the policies no later than 90 days after the changes occur, if applicable.
   - The Contractor's procedures for respecting those rights, including any limitations if applicable

8. 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 accredited as a managed care organization by either the National Committee for Quality Assurance (NCQA) or Joint Commission on Accreditation of Health Care Organizations (JCAHO) no later than September 30, 2003.
   - 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.
   - Complies with Medicaid Policy regarding procedures for authorization and reimbursement for out of network providers.

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 not employ, or hold any contracts or arrangements with, any individuals who have been suspended, debarred, or otherwise excluded under the Federal Acquisition Regulation as described in 42 CFR 438.610. This prohibition includes all 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.

   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.

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.

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 Michigan licensed registered nurse, or another licensed clinician as approved by DCH based on the plan's ability to demonstrate that the clinician possesses the training and

education to perform the duties of the quality improvement/utilization director outlined in the contract.

(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.

(f) Member Services Director

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 Director

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.

(j) Compliance Officer

Full-time compliance officer to oversee that a mandatory compliance plan is in place and all reporting of fraud and abuse guidelines are being followed as outlined in the Balanced Budget Act (BBA).

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 CMS. 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 CMS.

4. Management Information Systems

The Contractor must maintain a health information system that collects, analyzes, integrates, and reports data as required by DCH. The information system must have the capability for:

- Collecting data on enrollee and provider characteristics and on services provided to enrollees as specified by the State through an encounter data system;
- Supporting provider payments and data reporting between the Contractor and DCH;
- Controlling, processing, and paying providers for services rendered to Contractor Enrollees;
- Collecting service-specific procedures and diagnosis data, collecting price specific procedures or encounters (depending on the agreement between the provider and the Contractor), and maintaining detailed records of remittances to providers;
- Supporting all Contractor operations, including, but not limited to, the following:
    - Member enrollment, disenrollment, and capitation payments
    - Utilization
    - Provider enrollment
    - Third Party liability activity
    - Claims payment
    - Grievance and appeal 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

The Contractor must ensure that data received from providers is accurate and complete by:

- Verifying the accuracy and timeliness of the data;
- Screening the data for completeness, logic, and consistency;
- Collecting service information in standardized formats;
- Identification and tracking of fraud and abuse.

The Contractor is responsible for annual IRS form 1099 reporting of provider earnings and must make all collected data available to the State and, upon request, to CMS.

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 CMS 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. The Contractor must demonstrate 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. The delivery system (in and out of network) must include adequate numbers of providers with the training, experience, and specialization to furnish the covered services listed in Sections II-H and II-I of this contract to all Enrollees.

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.

The Contractor's provider network must meet the following requirements:

- Provides available, accessible and adequate numbers of facilities, locations, and personnel for the provision of Covered Services with adequate numbers of provider locations with provisions for physical access for Enrollees with physical disabilities;
- Has sufficient capacity to handle the maximum number of Enrollees specified under this Contract;
- Guarantees that emergency services are available seven days a week, 24-hours per day;
- Provides reasonable access to specialists based on the availability and distribution of such specialists. If the Contractor's provider network does not have a provider available for a second opinion within the network, the Enrollee must be allowed to obtain a second opinion from an out-of-network provider with prior authorization from the Contractor at no cost to the Enrollee;
- Provides adequate access to ancillary services such as pharmacy services, durable medical equipment services, home health services, and Maternal and Infant Support Services;
- Utilizes arrangements for laboratory services only through those laboratories with CLIA certificates;
- Contains only ancillary providers and facilities appropriately licensed or certified if required under 1978 PA 368, as amended;
- Responds to the cultural, racial and linguistic needs (including interpretive services as necessary) of the Medicaid population;

- Selected PCPs are accessible taking into account travel time, availability of public transportation and other factors that may determine accessibility;
- Primary care and hospital services are 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;
- Contracted PCPs provide or arrange for coverage of services 24 hours a day, 7 days a week;
- PCPs must be available to see patients a minimum of 20 hours per practice location per week.

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

(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) Coordination of Care with 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 on 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) Coordination of Care with Local Behavioral Health and Developmental Disability Providers

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.
- 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.
- Provides for continuity of treatment in the event a provider's participation terminates during the course of a member's treatment by that provider.
- Prohibit the provider from denying services to an individual who is eligible for the services due to the individual's inability to pay the co-payment.

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 422.208 and 422.210, as required in 42 CFR 438.6(h), in order to determine whether the incentive plans meet the requirements of 42 CFR 422.208-422.210 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 422.208 and 422.210 to any Enrollee.

(h) Provider Credentialing

The Contractor will have written credentialing and re-credentialing (at least every three 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. If the plan declines to include providers in the plan's network, the plan must give the affected providers written notice of the reason for the decision.

(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.

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.

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 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 credentialing 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 UB 92 (inpatient and outpatient claims) in the Medicare version 050 electronic format.

   (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.

   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 programs. 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 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.michigan.gov\mdch**

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.

4. Arbitration

   When a provider requests arbitration, 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.

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. These provisions also apply to out-of-network providers.

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-1and Section II-1-2 of this Contract.

8. Enrollee Liability for Payment

   The Enrollee may not be held liable for any of the following provisions consistent with 42 CFR Part 438.106 and 42 CFR 438.116:

   - The Contractors debts, in case of insolvency;
   - Covered services under this Contract provided to the Enrollee for which the State did not pay the Contractor;
   - Covered services provided to the Enrollee for which the State or the Contractor does not pay the provider due to contractual, referral or other arrangement; or
   - Payments for covered services furnished under a contract, referral, or other arrangement, to the extent that those payments are in excess of the amount that the Enrollee would owe if the Contractor provided the services directly.

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.
- 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.

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 for the services furnished to its enrollees that meets the requirements of 42 CFR 438.240. 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. The Contractor's Quality Assessment and Performance Improvement Program must also 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.

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.
- Determine underlying reasons for variations 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®, 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 at least twice annually and 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. Submit these parameters and protocols/guidelines to

providers with sufficient explanation and information to enable the providers to meet the established standards.

- The Contractor must ensure that where applicable, utilization management, enrollee education, coverage of services, and other areas as appropriate are consistent with the Contractor's practice guidelines.
- Evaluate access to care for Enrollees according to the established standards and those developed by DCH 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 or independently, and distribute results to providers, Enrollees, and DCH.
- Implement improvement strategies related to program findings and evaluate progress periodically but at least annually.
- Maintain Contractor's written Quality Assessment and Performance Improvement Program that will be available to DCH upon request.

2. 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 annually during the site visit and upon request.

3. Annual Performance Improvement Projects

   In addition to the internal Quality Assessment and Performance Improvement Program, the Contractor will conduct performance improvement projects that focus on clinical and non-clinical area. The Contractor must meet minimum performance objectives. The Contractor may be required to participate in statewide performance improvement projects.

   The DCH will collaborate with Stakeholders and Contractors to determine priority areas for statewide performance improvement projects. The 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, as defined by DCH. The Contractor will assess performance for the priority area(s) identified by DCH and/or other Stakeholders.

4. Performance Monitoring Standards

   DCH will establish and attach annual performance monitoring standards to the Contract (Attachment D). The Contractor will incorporate any statewide performance improvement objectives, established as a result of a statewide performance improvement project or monitoring, 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.

5. 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.

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 an NCQA certified CAHPS vendor and submitting the data according to the specifications and timelines established by the DCH.

II-Q UTILIZATION MANAGEMENT

The major components of the Contractor's utilization management program must encompass, at a minimum, the following:

- Written policies with review decision criteria and procedures that conform to 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 the review.
- The utilization management activities of the Contractor must be integrated with the Contractor's quality assessment and performance improvement program.

The Contractor must establish and use a written prior approval policy and procedure for utilization management purposes. The Contractor may not use such policies and procedures to avoid providing medically necessary services within the coverages established under the Contract. The policy must ensure that the review criteria for authorization decisions are applied consistently and require that the reviewer consult with the requesting provider when appropriate. The policy must also require that utilization management decisions be made by a health care professional who has appropriate clinical expertise regarding the service under review.

The Contractor's authorization policy must establish timeframes for standard and expedited authorization decisions. These timeframes may not exceed 14 days for standard authorization decisions and 3 working days for expedited authorization decisions. These timeframes may be extended up to 14 additional calendar days if requested by the provider or Enrollee and the Contractor justifies the need for additional information and explains how the extension is in the Enrollee's interest. The Enrollee must be notified of the plan's intent to extend the timeframe. The Contractor must ensure that compensation to individuals or subcontractor that conduct utilization management activities is not structured so as to provide incentives for the individual or subcontractor to deny, limit, or discontinue medically necessary services to any Enrollee.

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. If third party resources are available, the Contractor is not required to pay the provider first and then recover money from the third party. The Contractor should follow Medicaid Policy regarding third party liability.

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. The Contractor may retain all such collections. 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 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
    - Individual Contractor "Health Fair" for Enrollee Members
    - Malls or Commercial retail establishments
    - Community Centers
    - Churches

2. Prohibited Marketing Locations/Practices that target individual Beneficiaries:

- Local FIA offices
- Provider offices
- Hospitals
- Check cashing establishments
- Door-to-door marketing
- Telemarketing
- Clinics
- 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 marketing materials must be prior approved by DCH. 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 business days or the Contractor's request will be deemed approved.

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 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.

Materials must be written at no higher than 6th grade level as determined by any one of the following indices:

- Flesch – Kincaid
- 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.

II-T MEMBER AND ENROLLEE SERVICES

All written and oral materials directed to Enrollees must be prior approved by DCH. Upon receipt by DCH of a complete file of the proposed communication, the DCH will provide a decision to the Contractor within 30 business days or the Contractor's request will be deemed approved. All Enrollee services must address the need for culturally appropriate interventions. Reasonable accommodation must be made for Enrollees with hearing and/or vision impairments.

1. General

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 includes the toll free 24 hours a day, 7 days a week phone number for Enrollees to call and a unique identifying number for the Enrollee. The card must also identify the member's PCP name and phone number. Contractors may meet this requirement in one of the following ways:

- Print the PCP name and phone number on the card. (The Contractor must send a new card to the Enrollee when the PCP assignment changes.)
- Print the PCP name and phone number on a replaceable sticker to be attached to the card. (The Contractor must send a anew sticker to the Enrollee when the PCP assignment changes.)
- Any other method approved by DCH, provided that the PCP name and phone number is affixed to the card and the information changes when the PCP assignment changes.

The Contractor will demonstrate a commitment to case managing the complex health care needs of Enrollees. 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 two 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.

(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 the member ID Card to Enrollees via first class mail within ten business days of being notified of their enrollment. All other printed information,

including member handbook, provider directory, and information regarding accessing services may be mailed separately from the ID card. These materials do not have to be mailed via first class but must be mailed within ten business days of being notified of the member's enrollment.

Contractors may select the option of distributing new member packets to each household, instead of to each individual member in the household, provided that the mailing includes individual Health Plan membership cards for each member enrolled in the household. 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
- Information on how to choose and change PCPs
- 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 appeal process including how to register a grievance with the Contractor and/or State, how to file a written appeal, and the deadlines for filing an appeal and an expedited appeal
- 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
- 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
- Information regarding the Enrollee's right to obtain routine OB/GYN and Pediatric services from network providers without a referral.
- Information on how to obtain oral interpretation services and written information in Prevalent Languages, as defined by the Contract.
- Information on how to obtain written materials in alternative formats for enrollees with special needs.
- Information on Enrollee rights and responsibilities. The Enrollee rights information must include a statement that conveys that Contractor staff and affiliated providers will comply with all requirements concerning Enrollee rights.
- Information concerning advance directives that includes, at a minimum: (1) information about the Contractor's advance directives policy, (2) information regarding the State's advance directives law, and (3) directions on how to file a complaint with the State concerning noncompliance with the advance directive requirements. Any changes in the State law must be updated in this written information no later than 90 days following the effective date of the change.
- Any other information deemed essential by the Contractor and/or the DCH

The handbook must be written at no higher than a sixth grade reading level and must be available in alternative formats for Enrollees with special needs. Member handbooks must be available in the Prevalent Language other than English when more than five percent (5%) of the Contractor's Enrollees speak a Prevalent Language, as defined by the Contract. These Contractors must also provide a mechanism for Enrollees who speak the Prevalent Language to obtain member materials in the Prevalent Language or to obtain assistance with interpretation. The Contractor must submit all member handbook material to DCH for approval prior to distribution to the members. The Contractor must agree to make modifications in the handbook language so as to comply with the specifications of this Contract.

The Contractor must maintain a provider directory that contains, at a minimum, the following information:

- PCPs and Specialists listed by county.
- For PCP listings, the following information must be provided: Provider name, address, telephone number, any hospital affiliation, days and hours of operation, whether the provider is accepting new patients, and languages spoken.
- For Specialist listings, the following information must be provided: Provider name, address, telephone number, and any hospital affiliation.
- A list of all hospitals, pharmacies, medical suppliers, and other ancillary health providers the Enrollees may need to access. The list must contain the address and phone number of the provider.

Ancillary providers that are part of a retail chain may be listed by the name of the chain without listing each specific site.

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/APPEAL PROCEDURES

The Contractor will establish and maintain an internal process for the resolution of grievances and appeals from Enrollees. Enrollees may file a grievance or appeal on any aspect of service provided to them by the Contractor as specified in the definitions of grievance and appeal.

1. Contractor Grievance/Appeal Procedure Requirements

   The Contractor agrees to have written policies and procedures governing the resolution of grievances and appeals. These written policies and procedures will meet the following requirements:

   - The Contractor shall administer an internal grievance and appeal procedure according to the requirements of MCL 500.2213 and MCL 550.1404 and shall cooperate with the Michigan Office of Financial and Insurance Services in the implementation of MCL 550.1901-1929, "Patient's Rights to Independent Review Act."
   - The Contractor's internal grievance and appeal procedure must include the following components:
     - The Contractor must give Enrollees reasonable assistance in completing forms and taking other procedural steps. The Contractor must provide interpreter services and TTY/TDD toll free numbers.
     - The Contractor must acknowledge receipt of each grievance and appeal.
     - The Contractor must ensure that the individuals who make decisions on grievances and appeals are individuals:
       (i) Who were not involved in any previous level of review or decision-making; and
       (ii) Are health care professionals who have the appropriate clinical expertise in treating the Enrollee's condition or disease, when the grievance or appeal involves a clinical issue.

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 and any other time an Enrollee expresses dissatisfaction with the Contractor. The information will be included in the member handbook and will explain:

   - How to file a grievance with the Contractor
   - The internal grievance resolution process

3. Notice to Enrollees of Appeal Procedure

   The Contractor will inform Enrollees about the Contractor's appeal procedure at the time of initial enrollment, each time a service is denied, reduced, or terminated, and any other time a Contractor makes a decision that is subject to appeal under the definition of appeal in this Contract. The information will be included in the member handbook and will explain:

   - How to file an appeal with the Contractor
   - The internal appeal process
   - The member's right to a fair hearing with the State

   When the Contractor makes a decision subject to appeal, as defined in this contract, the Contractor must provide a written adverse action notice to the Enrollee and the requesting provider, if applicable. Adverse action notices for the suspension, reduction or termination of services must be made at least 10 days prior to the

change in services. Adverse action notices involving service authorization decisions that deny or limit services must be made within the time frames described in Section II-Q of this Contract. The notice must include the following components:

- The action the Contractor or subcontractor has taken or intends to take;
- The reasons for the action;
- The Enrollee's or Provider's right to file an Appeal;
- An explanation of the Contractor's Appeal Process;
- The Enrollee's right to request a Medicaid fair hearing;
- The circumstances under which expedited resolution is available and how to request it; and
- The Enrollee's right to have benefits continue pending resolution of the Appeal, how to request that benefits be continued, and the circumstances under which the Enrollee may be required to pay the costs of these services.

4. 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. The Contractor must include the Medicaid Fair Hearing Process as part of the written internal process for resolution of appeals and must describe the Medicaid Fair Hearing process in the Member Handbook.

5. Expedited Appeal Process

The Contractor's written policies and procedures governing the resolution of appeals must include provisions for the resolution of expedited appeals as defined in the Contract. These provisions must include, at a minimum, the following requirements:

- The Enrollee or provider may file an expedited appeal either orally or in writing.
- The Enrollee or provider must file a request for an expedited appeal within 10 days of the adverse determination.
- The Contractor will make a decision on the expedited appeal within 3 working days of receipt of the expedited appeal. This timeframe may be extended up to 10 calendar days if the enrollee requests the extension or if the Contractor can show that there is need for additional information and can demonstrate that the delay is in the Enrollee's interest. If the Contractor utilizes the extension, the Contractor must give the Enrollee written notice of the reason for the delay.
- The Contractor will give the Enrollee oral and written notice of the appeal review decision.
- If the Contractor denies the request for an expedited appeal, the Contractor will transfer the appeal to the standard 35-day timeframe and give the Enrollee written notice of the denial within 2 days of the expedited appeal request.
- The Contractor will not take any punitive actions toward a provider who requests or supports an expedited appeal on behalf of an Enrollee

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, fraud and abuse, and documentation. 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.

II-W CONTRACT REMEDIES AND SANCTIONS

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 sanctions will be implemented.

DCH may employ contract remedies and/or sanctions to address any Contractor noncompliance with the Contract; this includes, but is not limited to, noncompliance with Contract requirements on the following issues:

- Marketing practices
- Member services
- Provision of medically necessary, covered services
- Enrollment practices, including but not limited to discrimination on the basis of health status or need for health services
- Provider networks
- Provider payments
- Financial requirements, including but not limited to failure to comply with physician incentive plan requirements
- Enrollee satisfaction
- Performance standards included at Attachment D to the Contract
- Misrepresentation or false information provided to DCH, CMS, providers, Enrollees, or potential Enrollees.

The use of intermediate sanctions for non-compliance is described in 42 CFR 438.700. Intermediate sanctions employed by DCH may include suspension of enrollment and/or payment. Intermediate sanctions may also include the appointment of temporary management, as provided in 42 CFR 438.706, in cooperation with the Office of Financial and Insurance Services.

If intermediate sanctions are not successful or DCH determines that immediate termination of the Contract is appropriate, as allowed by Section I-O, the State will terminate the Contract with the Contractor. The Contractor must be afforded a hearing 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 sanctions described above, 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 sanction 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 F. 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.

Within the first 15 days of each new fiscal year, the Contractor's CEO must submit a DCH Data Certification form to DCH. The document must attest to the accuracy, completeness, and truthfulness of any and all data and documents submitted to the State as required by the Contract. When the health plan employs a new CEO, a new DCH Data Certification form must be submitted to DCH within 15 days of the employment date.

Submitted encounter data will be subject to edits prior to acceptance into DCH's data warehouse. Stored encounter data will be subject to regular and ongoing quality checks as developed by DCH. The Contractor's submission of encounter data must meet timeliness and completeness requirements as specified by DCH. The contractor must participate in regular data quality assessments conducted as a component of ongoing on-site activity described in Section II-V.

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:

1. HEDIS®

   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.

   Submitted encounter data will be subject to edits prior to acceptance into DCH's data warehouse. Stored encounter data will be subject to regular and ongoing quality checks as developed by DCH. The Contractor's submission of encounter data must meet timeliness and completeness requirements as specified by DCH. The Contractor must participate in regular data quality assessments conducted as a component of ongoing on site activity described in Section II-V.

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.

5. Semi-annual Grievance and Appeal Report

   The Contractor must track the number and type of grievances and appeals. This information should be summarized by the level at which the grievance or appeal was resolved.

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.

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 that 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 CMS shall be afforded prompt access to all Enrollees' medical records. Neither CMS nor DCH are required to obtain written approval from an Enrollee before requesting an Enrollee's medical record. When an Enrollee changes PCP, the former PCP must forward his or her medical records or copies of medical records to the new PCP within ten (10) working days from receipt of a written request.

II-AA SPECIAL PAYMENT PROVISIONS

1. 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:

   - 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.

2. 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.

   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

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 (mihealth card) to Enrollees.

- 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.
- 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.
- Monitor the operation of the Contractor to ensure access to quality care for Enrollees.
- 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.
- Implement mechanisms to identify persons with special health care needs.
- Assess the quality and appropriateness of care and services furnished to all of Contractor's Medicaid Enrollees and individuals with special health care needs utilizing information from required reports, on-site reviews, or other methods DCH determines appropriate.
- Identify the race, ethnicity, and primary language spoken of each Medicaid Enrollee. (State must provide this information to the Contractor at the time of enrollment).
- Regularly monitor and evaluate the Contractor's compliance with the standards.
- Protect against fraud and abuse involving Medicaid funds and Enrollees in cooperation with appropriate state and federal authorities.
- Make all fraud and/or abuse referrals to the office of Attorney General, Health Care Fraud Division.

II-CC PROGRAM INTEGRITY

The Contractor must have administrative and management arrangements or procedures, including a mandatory compliance plan. The Contractors' arrangements or procedures must include the following as defined in Section 438.608 of the Balanced Budget Act:

- Written policies and procedures that describe how the Contractor will monitor Fraud and Abuse.
- The designation of a compliance officer and a compliance committee who are accountable to the senior management or Board of Directors and who have effective lines of communication to the Contractor's employees.
- Effective training and education for the compliance officer and the Contractor's employees.
- Provisions for internal monitoring and auditing.
- Provisions for prompt response to detected offenses and development of corrective action initiatives.
- Documentation of the Contractor's enforcement of the Federal and State fraud and abuse standards.

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 (866) 428-0005 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.

SECTION III

CONTRACTOR INFORMATION

III-A BUSINESS ORGANIZATION

PRIMARY CONTRACTOR:

SUB-CONTRACTOR:

III-B AUTHORIZED CONTRACTOR EXPEDITER:

APPENDIX A

MODEL LOCAL AGREEMENT WITH LOCAL HEALTH DEPARTMENTS & MATRIX FOR COORDINATION OF SERVICES

(see file 10010 apndx A thru F.pdf)

APPENDIX B

MODEL LOCAL AGREEMENT WITH BEHAVIORAL PROVIDER

(see file 10010 apndx A thru F.pdf)

APPENDIX C

MODEL LOCAL AGREEMENT WITH DEVELOPMENTAL DISABILITY PROVIDER

(see file 10010 apndx A thru F.pdf)

APPENDIX D

FORMAT FOR PROFILES OF PRIMARY CARE PROVIDERS, SPECIALISTS, & ANCILLARY PROVIDER

(see file 10010 apndx A thru F.pdf)

APPENDIX E

KEY CONTRACTOR PERSONNEL AUTHORIZATION FOR RELEASE OF INFORMATION

(see file 10010 apndx A thru F.pdf)

APPENDIX F

HEALTH PLAN REPORTING FORMAT AND SCHEDULE

(see file 10010 apndx A thru F.pdf)

ATTACHMENT A

CONTRACTOR'S AWARDED PRICES

In compliance with 42 CFR 438.6 (c), the attached rates have been certified as actuarially sound by the Contractor.

ATTACHMENT B

APPROVED SERVICE AREAS

ATTACHMENT C

CORRECTIVE ACTION PLANS
(to be developed at a later date)

ATTACHMENT D

MEDICAID MANAGED CARE
PERFORMANCE STANDARDS

MEDICAID MANAGED CARE
PERFORMANCE STANDARDS
(Contract Year October 1, 2003 – September 30, 2004)

ATTACHMENT D – PERFORMANCE MONITORING STANDARDS

PURPOSE: The purpose of the performance monitoring 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. Through this attachment, the State incorporates the performance standards into the Contract between the State of Michigan and Contracting Medicaid Health Plans. Attachment D is a summary of the performance monitoring standards. Details on each performance monitoring standard are contained in the MDCH Performance Monitoring Standards Specifications.

The performance monitoring process is dynamic and reflects statewide issues that may change on a year- to-year basis. Performance measurement reports are shared with Health Plans during the year. The reports compare performance of each Plan over time, to other health plans, and to industry standards, where available.

The Performance Monitoring Standards reflect the following performance areas:

- Quality of Care
- Access to Care
- Customer Services
- Encounter Data
- Provider File reporting
- Claims Payment

Within each area, specific performance measures are identified including:

- Goal description
- Minimum Standard
- Data Source
- Monitoring Interval, (monthly, quarterly, annually)

Failure to meet the minimum performance monitoring standards may result in the implementation of remedial actions and/or improvement plans as outlined in the contract section II-W.

PERFORMANCE AREA	GOAL DESCRIPTION	MINIMUM STANDARD	DATA SOURCE	MONITORING INTERVALS
• **Quality of Care:** Childhood Immunization	Fully immunize children who turn two years old during the calendar year.	**Combination 1 □ 65%**	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	**□ 65%**	HEDIS report	Annual
• **Quality of Care:** Blood Lead Screening	Children at the age of 3 years that have had at least one blood lead test on/before 3rd birthday	**□ 40%**	Blood Lead Registry	Quarterly
• **Access to Care:** Well child visits First 15 months of Life	Children in the first 15 months of life receive one or more well child visits during 12 month period	**□ 90%**	Encounter data	Quarterly
• **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
• **Customer Services:** Enrollee complaints	Plans will have minimal enrollee contacts through Medicaid Helpline which are determined to be a complaint issue	**Complaint rate < 5 per 1000 member months**	Beneficiary/ Provider complaint tracking (BPCT)	Quarterly
• **Claims Reporting**	Health Plans are compliant with statutory requirements for payment of clean claims	**□90% clean claims paid within 30 days; ≤2% of ending inventory >45 days old**	Claims report submitted by health plan	Monthly
• **Encounter Data Reporting**	Timely and complete encounter data submission by the 15th of the month	**Timely and Complete**	MDCH Data Exchange Gateway (DEG)	Monthly
• **Provider File Reporting**	Timely provider file update/submission before the last Tuesday of the month	**Monthly submission**	MI Enrolls	Monthly

ATTACHMENT E

MODEL HEALTH PLAN/HOSPITAL CONTRACT

Exhibit 10.6

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

MEDICAL ASSISTANCE ADMINISTRATION

2003 – 2005 CONTRACT

Amendment 2

Effective January 1, 2004

FOR

HEALTHY OPTIONS

AND

STATE CHILDREN'S HEALTH INSURANCE PLAN

APPROVED AS TO FORM BY THE ATTORNEY GENERAL'S OFFICE

TABLE OF CONTENTS

1. **DEFINITIONS**

The following definitions shall apply to this agreement:

1.1. **Action** means the denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment of a service; or the failure to provide services or act in a timely manner as required herein (42 CFR 438.400(b)).

1.2. **Advance Directive** means a written instruction, such as a living will or durable power of attorney for health care, recognized under the laws of the state of Washington, relating to the provision of health care when an individual is incapacitated (WAC 388-501-0125, 42 CFR 438.6, 42 CFR 438.10, 42 CFR 422.128, and 42 CFR 489 Subpart I).

1.3. **Ancillary Services** means health services ordered by a provider including but not limited to, laboratory services, radiology services, and physical therapy.

1.4. **Appeal** means a request for review of an action (42 CFR 438.400(b)).

1.5. **Appeal Process** means the Contractor's procedures for reviewing an action.

1.6. **Children With Special Health Care Needs** means children identified by DSHS to the Contractor as meeting federal guidelines for such children. For the term of this agreement, DSHS will limit such identification to children served under the provisions of Title V of the Social Security Act.

1.7. **Cold Call Marketing** means any unsolicited personal contact by the Contractor with a potential enrollee or an enrollee with another HO/SCHIP contracted managed care organization for the purposes of marketing (42 CFR 438.104(a)).

1.8. **Comparable Coverage** means an enrollee has other insurance that DSHS has determined provides a full scope of health care benefits.

1.9. **Continuity of Care** means the provision of continuous care for chronic or acute medical conditions through enrollee transitions in providers, service areas and between HO/SCHIP contractors in a manner that does not interrupt medically necessary care or jeopardize the enrollee's health.

1.10. **Coordination of Care** means the Contractor's mechanisms to insure that the enrollee and providers have access to and take into consideration, all required information on the enrollee's conditions and treatments to ensure that the enrollee receives appropriate health care services.

1.11. **Covered Services** means medically necessary services, as set forth in Section 11, Schedule of Benefits, covered under the terms of this agreement.

1.12. **Dual Coverage** means an enrollee is privately enrolled on any basis with the Contractor and simultaneously enrolled with the Contractor under Healthy Options/SCHIP.

1.13. **EPSDT** (Early, Periodic Screening, Diagnosis and Treatment) means a package of services in a preventive (well child) exam covered by Medicaid as defined in the Social Security Act (SSA) Section 1905(r). Services covered by Medicaid include a complete health history and developmental assessment, an unclothed physical exam, immunizations, laboratory tests, health education and anticipatory guidance, and screenings for: vision, dental, substance abuse, mental health and hearing, as well as any medically necessary services found to be necessary during the EPSDT exam. EPSDT services covered by the Contractor are described in Sections 10.20 and 11, Schedule of Benefits.

1.14. **Eligible Clients** means DSHS clients certified eligible by the DSHS, living in the service area, and eligible to enroll for health care services under the terms of this agreement, as described in Section 2.2.

1.15. **Emergency Medical Condition** means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (a) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part (42 CFR 438.114(a)).

1.16. **Emergency Services** means covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish the services and are needed to evaluate or stabilize an emergency medical condition (42 CFR 438.114(a)).

1.17. **Enrollee** means an individual eligible for any medical program who is enrolled in Healthy Options/SCHIP managed care through a health care plan having an agreement with DSHS.

1.18. **Grievance** means an expression of dissatisfaction about any matter other than an action. Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights (42 CFR 438.400(b)).

1.19. **Grievance Process** means the procedure for addressing enrollees' grievances.

1.20. **Grievance System** means the overall system that includes grievances and appeals handled by the Contractor and access to the DSHS fair hearing system (42 CFR 438.400).

1.21. **Health Care Professional** means a physician or any of the following; a podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician (42 CFR 438.2).

1.22. **Managed Care** means a prepaid, comprehensive system of medical and health care delivery, including preventive, primary, specialty and ancillary health services.

1.23. **Marketing** means any communication from the Contractor to a potential enrollee or enrollees with another HO/SCHIP contracted managed care organization that can be reasonably interpreted as intended to influence them to enroll with the Contractor or either to not enroll in, or to disenroll from, another HO/SCHIP Managed Care Organization's Medicaid product (CFR 438.104(a)).

1.24. **Marketing Materials** means materials that are produced in any medium, by or on behalf of the Contractor, that can be reasonably interpreted as intended to market to potential enrollees or enrollees with another HO/SCHIP contracted managed care organization (42 CFR 438.104(a)).

1.25. **Medically Necessary Services** means services that meet the definition in WAC 388-500-0005.

1.26. **Participating Provider** means a person, health care provider, practitioner, as defined in the Quality Improvement Program Standards, Exhibit A, or entity, acting within their scope of practice, with a written agreement with the Contractor to provide services to enrollees under the terms of this agreement.

1.27. **Peer-Reviewed Medical Literature** means medical literature published in professional journals that submit articles for review by experts who are not part of the editorial staff. It does not include publications or supplements to publications primarily intended as marketing material for pharmaceutical, medical supplies, medical devices, health service providers, or insurance carriers.

1.28. **Physician Group** means a partnership, association, corporation, individual practice association, or other group that distributes income from the practice among its members. An individual practice association is a physician group only if it is composed of individual physicians and has no subcontracts with physician groups (42 CFR 434.70).

1.29. **Physician Incentive Plan** means any compensation arrangement between the Contractor and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services to enrollees under the terms of this agreement (42 CFR 434.70).

1.30. **Post-stabilization Services** means covered services, related to an emergency medical condition that are provided after an enrollee is stabilized in order to maintain the stabilized condition or to improve or resolve the enrollee's condition (42 CFR 438.114 and 42 CFR 422.113(c)).

1.31. **Potential Enrollee** means an individual eligible for enrollment in Healthy Options/SCHIP who is not enrolled with a health care plan having an agreement with DSHS (42 CFR 438.10).

1.32. **Primary Care Provider (PCP)** means a participating provider who has the responsibility for supervising, coordinating, and providing primary health care to enrollees, initiating referrals for specialist care, and maintaining the continuity of enrollee care. PCPs include, but are not limited to Pediatricians, Family Practitioners, General Practitioners, Internists, Physician Assistants (under the supervision of a physician), or Advanced Registered Nurse Practitioners (ARNP), as designated by the Contractor. The definition of primary care provider is inclusive of the definition of primary care physician in 42 CFR 400.203 and all Federal requirements for primary care physicians will be applicable to primary care providers as the term is used in this agreement.

1.33. **Risk** means the possibility that a loss may be incurred because the cost of providing services may exceed the payments made for services (42 CFR 434.2). When applied to subcontractors, loss includes the loss of potential payments made as part of a physician incentive plan, as defined herein.

1.34. **Service Area** means the geographic area covered by this agreement as described in Section 2.1.

1.35. **SCHIP:** State Children's Health Insurance Program.

1.36. **Subcontract** means a written agreement between the Contractor and a subcontractor, or between a subcontractor and another subcontractor, to perform all or a portion of the duties and obligations the Contractor is obligated to perform pursuant to this agreement.

2. **ENROLLMENT**

2.1. **Service Areas:**

2.1.1. The Contractor's service areas are described in Exhibit B, Premiums, Service Areas, and Capacity. DSHS shall update Exhibit B, Premiums, Service Areas, and Capacity for service area changes as describe herein.

2.1.2. Clients in the eligibility groups described in Section 2.2 are eligible to enroll with the Contractor if they reside in the Contractor's service areas.

2.1.3. Service Area Changes:

2.1.3.1. With the written approval of DSHS, the Contractor may expand into additional service areas at any time by giving written notice to DSHS, along with evidence, as DSHS may require, demonstrating the Contractor's ability to support the expansion. DSHS may withhold approval of a requested expansion, if, in DSHS' sole judgment, the requested expansion is not in the best interest of DSHS.

2.1.3.2. The Contractor may decrease service areas by giving DSHS ninety (90) calendar days written notice. The decrease shall not be effective until the first day of the month that falls after the ninety (90) calendar days has elapsed.

2.1.3.3. The Contractor shall notify enrollees affected by any service area decrease sixty (60) calendar days prior to the effective date. Notices shall have prior approval of DSHS. If the Contractor fails to notify affected enrollees of a service area decrease sixty (60) calendar days prior to the effective date, the decrease shall not be effective until the first day of the month which falls sixty (60) calendar days from the date the Contractor notifies enrollees.

2.1.4. If the U.S. Postal Service alters the zip code numbers or zip code boundaries within the Contractor's service areas, DSHS shall alter the service area zip code numbers or the boundaries of the service areas with input from the affected contractors.

2.1.5. DSHS shall determine, in its sole judgment, which zip codes fall within each service area. No zip code will be split between service areas.

2.1.6. DSHS will determine whether an enrollee resides within a service area.

2.2. **Eligible Client Groups:** DSHS shall determine eligibility for enrollment under this agreement. Clients in the following eligibility groups at the time of enrollment are eligible for enrollment under this agreement, and must enroll in Healthy Options/SCHIP unless the enrollee has dual coverage as defined herein, has comparable coverage as defined herein, or is exempted pursuant to Section 2.4.

2.2.1. Clients receiving Medicaid under Social Security Act (SSA) provisions for coverage of families receiving Temporary Assistance for Needy Families and clients who are not eligible for cash assistance who remain eligible for Medicaid.

2.2.2. Children, from birth through eighteen years of age, eligible for Medicaid under expanded pediatric coverage provisions of the Social Security Act ("H" Children).

2.2.3. Pregnant Women, eligible for Medicaid under expanded maternity coverage provisions of the Social Security Act ("S" women).

2.2.4. Children eligible for SCHIP.

2.3. **Client Notification:** DSHS shall notify eligible clients of their rights and responsibilities as Healthy Options/SCHIP enrollees at the time of initial eligibility determination and at least annually. The Contractor shall provide enrollees with additional information as described in this agreement, including the Quality Improvement Program Standards, Exhibit A.

2.4. **Exemption from Enrollment:** A client may request exemption from enrollment. Each request for exemption will be reviewed by DSHS pursuant to WAC 388-538 or WAC 388-542. When the client is already enrolled with the Contractor and wishes to be exempted, the exemption request will be treated as a disenrollment request consistent with the provisions of Section 2.9.

2.5. **Enrollment Period:** Subject to the provisions of Section 2.7, enrollment is continuously open. Enrollees shall have the right to change enrollment prospectively, from one Healthy Options/SCHIP plan to another without cause, each month (42 CFR 434.27).

2.6. **Enrollment Process:** To enroll with the Contractor, the client, his/her representative or his/her responsible parent or guardian must complete and submit a DSHS enrollment form to DSHS, or call the DSHS, Medical Assistance Administration's (MAA) toll-free enrollment number. If the client does not exercise his/her right to choose a Healthy Options/SCHIP plan, DSHS will assign the client, and all eligible family members, to a Healthy Options/SCHIP plan in accord with Section 4.10 of this agreement.

DSHS will make every effort to enroll all family members with the same Healthy Options/SCHIP plan. If a family member is covered by the Basic Health Plan, DSHS will make every effort to enroll the remainder of the family with the same managed care plan if the plan contracts with DSHS to provide Healthy Options/SCHIP. If the plan does not contract with DSHS, the remaining family members will be enrolled with a single, but different Healthy Options/SCHIP plan of the client's choice, or the client will be assigned as described above if they do not choose.

2.7. **Effective Date of Enrollment:**

2.7.1. Except for newborns, enrollment with the Contractor shall be effective on the later of the following dates:

2.7.1.1. If the enrollment is processed on or before the DSHS cut-off date for enrollment, enrollment shall be effective the first day of the month following the month in which the enrollment is processed; or

2.7.1.2. If the enrollment is processed after the DSHS cut-off date for enrollment, enrollment shall be effective the first day of the second month following the month in which the enrollment is processed.

2.7.2. Newborns whose mothers are enrollees shall be deemed enrollees and enrolled beginning from the newborn's date of birth or the mother's date of enrollment, whichever is later. If the mother is disenrolled before the newborn receives a separate client identifier from DSHS, the newborn's coverage shall end when the mother's coverage ends, except as provided in Section 3.7.

2.7.3. Adopted children shall be covered consistent with the provisions of Title 48 RCW.

2.7.4. No retroactive coverage is provided under this agreement, except as described in this section.

2.8. **Enrollment Listing and Requirements for Contractor's Response:**

2.8.1. Before the end of each month DSHS will provide the Contractor withan electronic file, via a Health Insurance Portability and Accountability Act (HIPAA) compliant secure web-based transfer system, a list of enrollees whose enrollment is terminated by the end of that month, and a list of the Contractor's enrollees for the following month.

2.8.2. The Contractor shall have ten (10) calendar days from the receipt of the enrollment listing to notify DSHS in writing of the refusal of an application for enrollment or any discrepancy regarding DSHS' proposed enrollment effective date. Written notice shall include the reason for refusal and must be agreed to by DSHS. The effective date of enrollment specified by DSHS shall be considered accepted by the Contractor and shall be binding if the notice is not timely or DSHS does not agree with the reasons stated in the notice. Subject to DSHS approval, the Contractor may refuse to accept an enrollee for the following reasons:

2.8.2.1 DSHS has enrolled the enrollee with the Contractor in a service area the Contractor is not contracted for.

2.8.2.2 The enrollee is not eligible for enrollment under the terms of this agreement.

2.9. **Termination of Enrollment:**

2.9.1. **Voluntary Termination:** Enrollees may request termination of enrollment by submitting a written request to terminate enrollment to DSHS or by calling the Medical Assistance Customer Service Center (MACSC) toll-free enrollment number. Requests for termination of enrollment may be made to enroll with another Healthy Options plan, or to disenroll from Healthy Options as provided in WAC 388-538 or WAC 388-542. Except as provided in WAC 388-538 or WAC 388-542, enrollees whose enrollment is terminated will be prospectively disenrolled. DSHS shall notify the Contractor of enrollee terminations pursuant to Section 2.8. The Contractor may not request voluntary disenrollment on behalf of an enrollee.

2.9.2. **Involuntary Termination Initiated by DSHS for Ineligibility:** The enrollment of any enrollee under this agreement shall be terminated if the enrollee becomes ineligible for enrollment due to a change in eligibility status.

2.9.2.1. When an enrollee's enrollment is terminated for ineligibility, the termination shall be effective:

2.9.2.1.1. The first day of the month following the month in which the termination is processed by DSHS if the termination is processed on or before the DSHS cut-off date for enrollment or the Contractor is informed by DSHS of the termination prior to the first day of the month following the month in which the termination is processed by DSHS.

2.9.2.1.2. Effective the first day of the second month following the month in which the termination is processed if the termination is processed after the DSHS cut-off date for enrollment and the Contractor is not informed by DSHS of the termination prior to the first day of the month following the month in which the termination is processed by DSHS.

2.9.2.2 Enrollees Eligible for Social Security Income (SSI):

2.9.2.2.1. Newborn enrollees with a date-of-birth after calendar year 2003 who are determined by the Social Security Administration (SSA) to have an SSI eligibility effective date within the first sixty-days of life, not counting the birth date, shall be ineligible for services under the terms of this agreement when DSHS receives the SSI eligibility information from the SSA through the State Data Exchange (SDX). Such newborn enrollees will be disenrolled retroactively effective the date-of-birth. DSHS shall recoup premiums paid in accord with Section 3.5.5.

2.9.2.2.2. Except as provided in Section 2.9.2.2.1., enrollees determined by the SSA to be eligible for SSI shall be ineligible for services under the terms of this agreement when DSHS receives the SSI eligibility information from the SSA through the electronic SDX. Such enrollees will be disenrolled prospectively as described in Section 2.9.2.1. DSHS shall not recoup any premiums for enrollees determined SSI eligible and the Contractor shall be responsible for providing services under the terms of this agreement until the effective date of disenrollment.

2.9.2.2.3. If the Contractor believes an enrollee has been determined by SSA to be eligible for SSI, the Contractor shall present documentation of such eligibility to DSHS, DSHS will attempt to verify the eligibility and, if the enrollee is SSI

eligible, DSHS will act upon SSI eligibility in accord with this section.

2.9.3. **Involuntary Termination Initiated by DSHS for Comparable Coverage or Dual Coverage**:

2.9.3.1. The Contractor shall notify DSHS as set forth below when an enrollee has health care insurance coverage with the Contractor or any other carrier:

2.9.3.1.1. Within fifteen (15) working days when an enrollee is verified as having dual coverage, as defined herein.

2.9.3.1.2. Within sixty (60) calendar days of when the Contractor becomes aware that an enrollee has any health care insurance coverage with any other insurance carrier. The Contractor is not responsible for the determination of comparable coverage, as defined herein.

2.9.3.2. DSHS will involuntarily terminate the enrollment of any enrollee with dual coverage or comparable coverage as follows:

2.9.3.2.1. When the enrollee has dual coverage that has been verified by DSHS, DSHS shall terminate enrollment retroactively to the beginning of the month of dual coverage and recoup premiums as describe in Section 3.5.

2.9.3.2.2. When the enrollee has comparable coverage which has been verified by DSHS, DSHS shall terminate enrollment effective the first day of the second month following the month in which the termination is processed if the termination is processed on or before the DSHS cut-off date for enrollment or, effective the first day of the third month following the month in which the termination is processed if the termination is processed after the DSHS cut-off date for enrollment.

2.9.4. **Involuntary Termination Initiated by the Contractor:** To request involuntary termination of an enrollee, the Contractor shall send written notice to DSHS as described in Section 7.5. DSHS shall approve or disapprove the request for termination within thirty (30) working days of receipt of such notice. For the termination to be effective, DSHS must approve the termination request, notify the Contractor, and disenroll the enrollee. The Contractor shall continue to provide services to the enrollee until s/he is disenrolled. DSHS will not disenroll an enrollee solely due to a request based on an adverse

change in the enrollee's health status or the cost of meeting the enrollee's health care needs (WAC 388-538-130). DSHS shall involuntarily terminate the enrollee when the Contractor has substantiated in writing:

2.9.4.1. The enrollee's behavior is inconsistent with the Contractor's rules and regulations, such as intentional misconduct.

2.9.4.2. The Contractor has provided a clinically appropriate evaluation to determine whether there is a treatable condition contributing to the enrollee's behavior and such evaluation either finds no treatable condition to be contributing, or, after evaluation and treatment, the enrollee's behavior continues to prevent the provider from safely or prudently providing medical care to the enrollee.

2.9.4.3. The enrollee received written notice from the Contractor of its intent to request the enrollee's disenrollment, unless the requirement for notification has been waived by DSHS because the enrollee's conduct presents the threat of imminent harm to others. The Contractor's notice to the enrollee shall include the enrollee's right to use the Contractor's grievance process to review the request to end the enrollee's enrollment.

2.9.5. An enrollee whose enrollment is terminated for any reason, other than incarceration, at any time during the month is entitled to receive covered services, as described in Section 10.1, at the Contractor's expense, through the end of that month.

In no event will an enrollee be entitled to receive services and benefits under this agreement after the last day of the month in which his or her enrollment is terminated, except as provided in Section 3.7.

2.10. **Enrollment Not Discriminatory**

2.10.1. The Contractor will not discriminate against enrollees or potential enrollees on the basis of health status or need for health care services (42 CFR 438.6 (d)(3)).

2.10.2. The Contractor will not discriminate against enrollees or potential enrollees on the basis of race, color, or national origin, and will not use any policy or practice that has the effect of discriminating on the basis of race, color, or national origin (42 CFR 438.6 (d)(4)).

3. **PAYMENT**

3.1. **Rates/Premiums:** Subject to the provisions of Section 7.7, Intermediate Sanctions, DSHS shall pay a monthly premium for each enrollee in full consideration of the work to be performed by the Contractor under this agreement. DSHS shall pay the Contractor, on or before the tenth (10th) working day of the month based on the DSHS list of enrollees whose enrollment is ongoing or effective on the first day of said calendar month. Such payment will be denied for new enrollees when, and for so long as, payment for those enrollees is denied by the Centers for Medicare and Medicaid Services (CMS) under 42 CFR 438.726(b) and 42 CFR 438.730(e).

The Contractor shall reconcile the payment listing with remittance advice information and submit a claim to DSHS for any amount due the Contractor within three hundred sixty five (365) calendar days of the month of service. When DSHS' records confirm the Contractor's claim, DSHS shall remit payment within thirty (30) calendar days of the receipt of the claim.

3.1.1. The statewide Base Rate, Geographical Adjustment Factors, Risk Adjustment Factors and Age/Sex Factors are in Exhibit B, Premiums, Service Areas, and Capacity.

3.1.2. The monthly premium payment will be calculated as follows:

Premium Payment = Base Rate x Age/Sex Factor x Risk Adjustment Factor x Geographical Adjustment Factor (X Quality Adjustment Factor as describe herein).

3.1.3. Within thirty (30) calendar days following the end of the 2004 legislative session, DSHS will publish the Base Rate and Geographical Adjustment Factors for calendar year 2005. If the Contractor will not continue to provide HO/SCHIP services in 2005, the Contractor shall so notify DSHS no later than September 2, 2004 under the provisions of Section 7.5 Notices. If the Contractor so notifies DSHS, this agreement shall terminate, without penalty to either party, effective midnight, December 31, 2004. The termination will be considered a termination for convenience under the provisions of Section 9.2, Termination for Convenience, but neither party shall have the right to assert a claim for costs.

3.1.4. The Risk Adjustment Factor will be recalculated for premiums paid beginning in May for each year based on enrollment with the Contractor on March 1st of that year, using encounter data reported for the 12 months ending June 30 of the previous year. Risk Adjustment

Factors may also be recalculated by DSHS if, in DSHS' sole judgment, changes in contractor participation in HO/SCHIP require rebalancing of the Risk Adjustment Factors.

3.1.5. In 2004 DSHS will develop a Quality Adjustment Factor. In 2004 DSHS will separately report to the Contractor the affect such a Quality Adjustment Factor would have on the premium payments to the Contractor. In 2004 the adjustment factor will not be applied to actual premium payments. In 2005 DSHS will begin implementation of a Quality Adjustment Factor and apply it to 2005 premium payments. At its sole discretion, DSHS may choose not to implement the Quality Adjustment Factor in 2005 or implement the Quality Adjustment Factor later than January 1, 2005. The Quality Adjustment Factor will be provided to the Contractor at least one hundred and fifty (150) calendar days before implementation. If the Contractor does not accept the Quality Adjustment Factor, the Contractor may terminate this agreement with one hundred and twenty (120) calendar days notice under the provision of Section 7.5 Notices. The termination will be considered a termination for convenience under the provisions of Section 9.2, Termination for Convenience, but neither party shall have the right to assert a claim for costs.

3.1.6. DSHS will update Exhibit B, Premiums, Service Areas, and Capacity to add the Base Rate for 2005 and for changes in service areas, capacity and Risk Adjustment Factors as needed and without amending this agreement. DSHS will provide such updates to the Contractor.

3.1.7. DSHS shall automatically generate newborn premiums whenever possible. For newborns whose premiums DSHS is not able to automatically generate the Contractor shall submit a supplemental premium payment request to DSHS within 365 calendar days of the month of service. The Contractor shall be responsible for reviewing monthly listings provided by DSHS of the newborn premiums DSHS cannot generate automatically, as well as remittance advice statements, to determine whether a supplemental premium request needs to be submitted. DSHS shall pay supplemental premiums through the end of the month in which the sixtieth (60th) day of life occurs.

3.1.8. DSHS shall make a full monthly payment to the Contractor for the month in which an enrollee's enrollment is terminated except as otherwise provided herein.

3.1.9. The Contractor shall be responsible for covered medical services provided to the enrollee in any month for which DSHS paid the Contractor for the enrollee's care under the terms of this agreement.

3.2. **Delivery Case Rate Payment:** A one-time payment of $4,300.00 shall be made to the Contractor for labor and delivery expenses for enrollees enrolled with the Contractor during the month of delivery. Delivery includes both live and stillbirths, but does not include miscarriage, induced abortion, or other fetal demise not requiring labor and delivery to terminate the pregnancy. The Contractor shall submit a supplemental premium request for payment to DSHS after the enrollee delivers.

3.3. **Renegotiation of Rates:** The base rate set forth herein shall be subject to renegotiation during the agreement period only if DSHS, in its sole judgment, determines that it is necessary due to a change in federal or state law or other material changes, beyond the Contractor's control, which would justify such a renegotiation.

3.4. **Reinsurance/Risk Protection:** The Contractor may obtain reinsurance for coverage of enrollees only to the extent that it obtains such reinsurance for other groups enrolled by the Contractor, provided that the Contractor remains ultimately liable to DSHS for the services rendered.

3.5. **Recoupments:** Unless mutually agreed to by the parties, DSHS shall only recoup premium payments for enrollees who are:

3.5.1. Dually-covered with the Contractor.

3.5.2. Deceased prior to the month of enrollment. Premium payments shall be recouped effective the first day of the month following the enrollee's date of death.

3.5.3. Retroactively disenrolled as a result of the enrollee's placement in foster care.

3.5.4. Retroactively disenrolled consistent with the provisions of Section 2.9.1.

3.5.5. Newborns determined to have an SSI eligibility effective date within the first sixty (60) days of life in accord with Section 2.9.2.2.1. DSHS shall recoup all premiums paid for the enrollee, but not the birth mother, back to the date-of-birth.

3.5.6. Found ineligible for enrollment with the Contractor and DSHS so notifies the Contractor before the first day of the month for which the premium is paid.

3.5.7. The Contractor may recoup payments made to providers for services provided to enrollees during the period for which DSHS recoups

premiums for those enrollees. If the Contractor recoups said payments, providers may submit appropriate claims for payment to DSHS through its FFS program.

3.6. **Enrollee Hospitalized at Enrollment:**

3.6.1. If an enrollee is in an acute care hospital at the time of enrollment and was not enrolled in Healthy Options/SCHIP on the day the enrollee is admitted to the hospital, DSHS shall be responsible for payment of all inpatient facility and professional services provided from the date of admission until the date the enrollee is no longer confined to an acute care hospital.

3.6.2. If an enrollee is enrolled in Healthy Options/SCHIP on the day the enrollee was admitted to an acute care hospital, then the plan the enrollee is enrolled with on the date of admission shall be responsible for payment of all inpatient facility and professional services provided from the date of admission until the date the enrollee is no longer confined to an acute care hospital.

3.6.3. Except as provided in Section 3.6.4., for newborns born while their mother is hospitalized, the party responsible for the payment for the mother's hospitalization shall be responsible for payment of all inpatient facility and professional services provided to the newborn from the date of admission until the date the newborn is no longer confined to an acute care hospital.

3.6.4. For newborns who are disenrolled retroactive to the date of birth and whose premiums are recouped as provided herein, DSHS shall be responsible for payment of all inpatient facility and professional services provided to and associated with the newborn. The provisions of 3.6.1. or 3.6.2. shall apply for services provided to and associated with the mother.

3.6.5. If DSHS is responsible for payment of all inpatient facility and professional services provided to a mother, DSHS shall not pay the Contractor a Delivery Case Rate under the provisions of Section 3.2.

3.7. **Enrollee Hospitalized at Disenrollment:** If an enrollee is in an acute care hospital at the time of disenrollment and the enrollee was enrolled with the Contractor on the date of admission, the Contractor shall be responsible for payment of all covered inpatient facility and professional services from the date of admission to the date the enrollee is no longer confined to an acute care hospital.

3.8. **Third-Party Liability (TPL):** Until such time as DSHS shall terminate the enrollment of an enrollee who has comparable coverage as described in Section 2.9.3., the services and benefits available under this agreement shall be secondary to any other medical coverage. The Contractor shall:

3.8.1. Not refuse or reduce services provided under this agreement solely due to the existence of similar benefits provided under any other health care contracts (RCW 48.21.200), except in accord with applicable coordination of benefits rules in WAC 284-51.

3.8.2. Attempt to recover any third-party resources available to enrollees (42 CFR 433 Subpart D) and shall make all records pertaining to TPL collections for enrollees available for audit and review.

3.8.3. Pay claims for prenatal care and preventive pediatric care and then seek reimbursement from third parties (42 CFR 433.139(b)(3)).

3.8.4. Pay claims for covered services when probable third party liability has not been established or the third party benefits are not available to pay a claim at the time it is filed (42 CFR 433.139(c)).

3.8.5. Communicate the requirements of this section to subcontractors that provide services under the terms of this agreement, and assure compliance with them.

3.9. **Subrogation Rights of Third-Party Liability:** Injured person means an enrollee covered by this agreement who sustains bodily injury. Contractor's medical expense means the expense incurred by the Contractor for the care or treatment of the injury sustained computed in accord with the Contractor's fee-for-service schedule.

If an enrollee requires medical services from the Contractor as a result of an alleged act or omission by a third-party giving rise to a claim of legal liability against the third-party, the Contractor shall have the right to obtain recovery of its cost of providing benefits to the injured person from the third-party. DSHS specifically assigns to the Contractor the DSHS' rights to such third party payments for medical care provided to an enrollee on behalf of DSHS, which the enrollee assigned to DSHS as provided in WAC 388-505-0540.

DSHS also assigns to the Contractor its statutory lien under RCW 43.20B.060. The Contractor shall be subrogated to the DSHS' rights and remedies under RCW 74.09.180 and RCW 43.20B.040 through RCW 43.20B.070 with respect to medical benefits provided to enrollees on behalf of DSHS under RCW 74.09.

The Contractor may obtain a signed agreement from the enrollee in which the enrollee agrees to fully cooperate in effecting collection from persons

causing the injury. The agreement may provide that if an injured party settles a claim without protecting the Contractor's interest, the injured party shall be liable to the Contractor for the full cost of medical services provided by the Contractor. The Contractor shall notify DSHS of the name, address, and other identifying information of any enrollee and the enrollee's attorney who settles a claim without protecting the Contractor's interest in contravention of RCW 43.20B.050.

3.10. **Rate Setting Methodology:** Managed care base rates are set based on the state allocation of program funding. For 2003 an additional increase was applied to account for a policy change regarding enrollees who become eligible for SSI as discussed in more detail below. Many rating factors are reviewed to ensure that the rates are developed using actuarially sound methodology, including the following:

3.10.1. Geographic area factors are reviewed and updated each year based on plan financial experience.

3.10.2. Using the CDPS risk adjustment model plan encounter data is used to generate plan specific risk scores which are periodically updated.

3.10.3. A policy change was made to the program effective January 1, 2003. Historically, retroactive SSI eligibility was recognized with the recoupment of capitation payments (managed care premiums) with the associated payment of claims on a fee-for-service basis. The policy change removes the retroactive adjustments and simply disenrolls these members prospectively upon notification of SSI eligibility. A rate adjustment was made to the capitation rates to account for this cost shift to the managed care plans.

3.11. **Copayments:** The Contractor may impose copayments for services to enrollees for the same services, populations and amounts that DSHS implements in its fee-for-service program.

4. **ACCESS AND CAPACITY**

4.1. **Network Capacity:**

4.1.1. The Contractor agrees to maintain the support services and a provider network sufficient to serve the enrollee capacity stated in Exhibit B, Premiums, Service Areas, and Capacity, consistent with the requirements of this agreement.

4.1.2. The Contractor agrees to provide the medical services required by this agreement through non-participating providers, at a cost to the enrollee that is no greater than if the services were provided by participating providers, if its network of participating providers is insufficient to meet the medical needs of enrollees in a manner consistent with this agreement.

4.1.3. With the written approval of DSHS, the Contractor may increase capacity at any time by giving written notice to DSHS, along with evidence, as DSHS may require, demonstrating the Contractor's ability to support the capacity increase. DSHS may withhold approval of a requested capacity increase, if, in DSHS' sole judgment, the requested increase is not in the best interest of DSHS. The Contractor may decrease capacity by giving DSHS ninety (90) calendar days written notice. The decrease shall not be effective until the first day of the month which falls after the ninety (90) calendar days has elapsed. Exhibit B, Premiums, Service Areas, and Capacity will be updated by DSHS for increases and decreases in capacity.

4.2. **Accessibility of Services:** The Contractor shall make services accessible consistent with the provisions in the Quality Improvement Program Standards, Exhibit A. The Contractor shall make covered services as accessible to enrollees under this agreement as under its other state, federal, or private contracts.

4.3. **24/7 Availability:** The Contractor shall have the following services available on a 24-hour-a-day, seven-day-a-week basis by telephone. These services may be provided directly by the Contractor or may be delegated to subcontractors.

4.3.1. Medical advice for enrollees from licensed health care professionals concerning the emergent, urgent or routine nature of medical condition.

4.3.2. Authorization of services.

4.4. **Appointment Standards:** The Contractor shall comply with appointment standards that are no longer than the following:

4.4.1. Non-symptomatic (i.e. preventive care) office visits shall be available from the enrollee's PCP or an alternative practitioner within thirty (30) calendar days. A non-symptomatic office visit may include, but is not limited to, well/preventive care such as physical examinations, annual gynecological examinations, or children and adult immunizations.

4.4.2. Non-urgent, symptomatic (i.e., routine care) office visit shall be available from the enrollee's PCP or an alternative practitioner within seven (7)

calendar days. A non-urgent, symptomatic office visit is associated with the presentation of medical signs not requiring immediate attention.

4.4.3. Urgent, symptomatic office visits shall be available within 24 hours. An urgent, symptomatic visit is associated with the presentation of medical signs that require immediate attention, but are not life threatening.

4.4.4. Emergency medical care shall be available 24 hours per day, seven days per week.

4.5. **Provider Network - Distance Standards:** The Contractor network of providers shall meet the distance standards below in every service area. The designation of a zip code in a service area as rural or urban is in Exhibit B, Premiums, Service Areas, and Capacity. DSHS may, at its sole discretion, grant exceptions to the distance standards. DSHS' approval of an exception shall be in writing. The Contractor shall request an exception in writing and shall provide evidence as DSHS may require to support the request. If the closest qualified provider is beyond the distance standard applicable to the zip code, the distance standard defaults to the distance to that provider. The closest qualified provider may be a provider not participating with the Contractor.

4.5.1. PCP

Urban: 2 within 10 miles for 90% of Healthy Options enrollees in the Contractor's service area.

Rural: 1 within 25 miles for 90% of Healthy Options enrollees in the Contractor's service area.

4.5.2. Obstetrics

Urban: 2 within 10 miles for 90% of Healthy Options enrollees in the Contractor's service area.

Rural: 1 within 25 miles for 90% of Healthy Options enrollees in the Contractor's service area.

4.5.3. Pediatrician or Family Practice Physician Qualified to Provide Pediatric Services

Urban: 2 within 10 miles for 90% of Healthy Options enrollees in the Contractor's service area.

Rural: 1 within 25 miles for 90% of Healthy Options enrollees in the Contractor's service area.

4.5.4. Hospital

Urban/Rural: 1 within 25 miles for 90% of Healthy Options enrollees in the Contractor's service area.

4.5.5. Pharmacy

Urban: 1 within 10 miles for 90% of Healthy Options enrollees in the Contractor's service area.

Rural: 1 within 25 miles for 90% of Healthy Options enrollees in the Contractor's service area.

4.6. **Access to Specialty Care:** The Contractor shall provide all medically necessary specialty care for enrollees in a service area. If an enrollee needs specialty care from a specialist who is not available within the Contractor's provider network, the Contractor shall provide the necessary services with a qualified specialist outside the Contractor's provider network.

4.7. **Equal Access for Enrollees and Potential Enrollees with Communication Barriers:** The Contractor shall assure equal access for all enrollees and potential enrollees when oral or written language creates a barrier to such access for enrollees and potential enrollees with communication barriers

4.7.1. **Oral Information:**

4.7.1.1. The Contractor shall assure that interpreter services are provided for enrollees and potential enrollees with a primary language other than English for all interactions between the enrollee or potential enrollee and the Contractor or any of its providers including, but not limited to, customer services, all appointments with any provider for any covered service, emergency services, and all steps necessary to file grievances and appeals.

4.7.1.2. The Contractor is responsible for payment for interpreter services for plan administrative matters including, but not limited to handling enrollee grievances and appeals.

4.7.1.3. DSHS is responsible for payment for interpreter services provided by interpreter agencies contracted with the state for outpatient medical visits and DSHS fair hearings.

4.7.1.4. Hospitals are responsible for payment for interpreter services during inpatient stays.

4.7.1.5. Public entities are responsible for payment for interpreter services provided at their facilities or affiliated sites.

4.7.1.6. Interpreter services include the provision of interpreters for enrollees and potential enrollees who are deaf or hearing impaired.

4.7.2. **Written Information:**

4.7.2.1. The Contractor shall provide all generally available and client specific written materials in a form which may be understood by each individual enrollee and potential enrollee. The Contractor may meet this requirement by doing one of the following:

4.7.2.1.1. Translating the material into the enrollee's or potential enrollee's primary reading language.

4.7.2.1.2. Providing the material on tape in the enrollee's or potential enrollee's primary language.

4.7.2.1.3. Having an interpreter read the material to the enrollee or potential enrollee in the enrollee's primary language.

4.7.2.1.4. Providing the material in another alternative medium or format acceptable to the enrollee or potential enrollee. The Contractor shall document the enrollee's or potential enrollee's acceptance of the alternative.

4.7.2.1.5. Providing the material in English, if the Contractor documents the enrollee's or potential enrollee's preference for receiving material in English.

4.7.2.2. The Contractor shall ensure that all written information provided to enrollees or potential enrollees is comprehensible to its intended audience, designed to provide the greatest degree of understanding, and is written at the sixth grade reading level. Generally available, written materials shall be consumer tested.

4.8. **Americans with Disabilities Act:** The Contractor shall make reasonable accommodation for enrollees with disabilities, in accord with the Americans with Disabilities Act, for all covered services and shall assure physical and communication barriers shall not inhibit enrollees with disabilities from obtaining covered services.

4.9. **Capacity Limits and Order of Acceptance:** The Contractor shall provide care to enrollees up to the capacity limits in Exhibit B, Premiums, Service Areas, and Capacity. The Contractor shall accept enrollees up to the total capacity limit in each service area, and enrollees will be accepted in the order in which they apply. DSHS shall enroll all eligible clients with the contractor of their choice if the Contractor has not reached the capacity limit unless DSHS determines, in its sole judgment, that it is in DSHS' best interest to withhold or limit enrollment with the Contractor. The Contractor shall accept clients who are assigned by DSHS in accord with this

agreement, WAC 388-538, and WAC 388-542, except as specifically provided in Section 2.8.

No eligible client shall be refused enrollment or re-enrollment, have his/her enrollment terminated, or be discriminated against in any way because of his/her health status, the existence of a pre-existing physical or mental condition, including pregnancy and/or hospitalization, or the expectation of the need for frequent or high cost care.

4.10. **Assignment of Enrollees:**

4.10.1. Enrollees who do not select a plan in a service area identified by DSHS as having mandatory enrollment into managed care shall be assigned to a plan in the following manner:

4.10.1.1. DSHS shall determine the total capacity of all contractors receiving assignments in each service area.

4.10.1.2. The Contractor's capacity in each service area, as stated in Exhibit B, Premiums, Service Areas, and Capacity, modified by increases and decreases in capacity made in accord with this agreement, shall be divided by the total capacity of all contractors receiving assignment in each service area.

4.10.1.3. The result of the calculation in 4.10.1.2. will be multiplied by the total of the households to be assigned.

4.10.1.4. DSHS shall assign the number of households determined in 4.10.1.3. to the Contractor.

4.10.2. DSHS shall not make any assignments of enrollees to the Contractor in a service area if the Contractor's enrollment, when DSHS calculates assignments, is ninety percent (90%) or more of its capacity in that service area.

4.10.3. The Contractor may choose not to receive assignments or limit assignments in any service area by so notifying DSHS in writing at least seventy-five (75) calendar days before the first of the month it is requesting not to receive assignment of enrollees.

4.10.4. DSHS reserves the right to make no assignments, or to withhold or limit assignments to the Contractor, when, in its sole judgment, it is in the best interest of DSHS.

4.10.5. If either the Contractor or DSHS limits assignments as described herein, the Contractor's capacity, only for the purposes of the calculation in 4.10.1.2., shall be that limit.

4.10.6. Assigned enrollees are notified by DSHS of their assignment and may choose a different managed care organization prior to the effective date of their assignment.

4.11. **Provider Network Changes:**

4.11.1. The Contractor shall give DSHS a minimum of ninety (90) calendar days prior written notice, in accord with Section 7.5, Notices, of the loss of a material provider. A material provider is one whose loss would impair the Contractor's ability to provide continuity of and access to care for the Contractor's current enrollees and/or the number of enrollees the Contractor has agreed to serve in a service area.

4.11.2. The Contractor shall make a good faith effort to notify enrollees affected by any provider termination within fifteen (15) calendar days after receiving or issuing a provider termination notice (42 CFR 438.10(f)(5). Enrollee notices shall have prior approval of DSHS. If the Contractor fails to notify affected enrollees of a provider termination at least sixty (60) calendar days prior to the effective date of termination, the Contractor shall allow affected enrollees to continue to receive services from the terminating provider, at the enrollees' option, and administer benefits for the lesser of a period ending the last day of the month in which sixty (60) calendar days elapses from the date the Contractor notifies enrollees or the enrollee's effective date of enrollment with another plan.

4.12. **Women's Health Care Services:** In the provision of women's health care services, the Contractor shall comply with the provisions of WAC 284-43-250 and 42 CFR 438.206(b)(2).

4.13. **Maternity Newborn Length of Stay:** The Contractor shall ensure that hospital delivery maternity care is provided in accord with RCW 48.43.115.

4.14. **Cultural Considerations:** The Contractor shall participate in and cooperate with DSHS' efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds (42 CFR 438.206(c)(2)).

5. **QUALITY OF CARE**

5.1. **Quality Improvement Program:**

5.1.1. The Contractor shall maintain a quality assessment and performance improvement (QAPI) program for the services it furnishes to its enrollees that meets the provisions of 42 CFR 438, Subpart D, Medicaid Managed Care Protocols located at www.cms.hhs.gov/medicaid/managedcare/mceqrhmp.asp, the provisions of this agreement, and the Quality Improvement Program Standards, Exhibit A.

5.1.2. The Contractor shall, during an annual review or upon request by DSHS or its External Quality Review Organization (EQRO) contractor(s), provide evidence of how external quality review findings, agency audits and contract monitoring activities, enrollee grievances, HEDIS® and CAHPS® results, are used to identify and correct problems and to improve care and services to enrollees.

5.1.3. The Contractor shall include the following basic elements in its Quality Improvement program (42 CFR 438.240(b)):

5.1.3.1. Conduct performance improvement projects described herein.

5.1.3.2. Have in effect mechanisms to detect both underutilization and overutilization of services.

5.1.3.3. Have in effect mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs.

5.2. **Accreditation:** If the Contractor has had an accreditation review or visit by NCQA or another accrediting body, the Contractor shall provide the complete report from that organization to DSHS. If permitted by the accrediting body, the Contractor shall allow a state representative to accompany any accreditation review team during the site visit in an official observer status. The state representative shall be allowed to share information with DSHS, Department of Health (DOH), and Health Care Authority (HCA) as needed to reduce duplicated work for both the Contractor and the state.

5.3. **Performance Improvement Projects:**

5.3.1. The Contractor shall conduct at least five (5) Performance Improvement Projects (PIPs) of which at least three (3) are clinical and at least two (2) are non-clinical as described in 42 CFR 438.240 and as specified in the CMS protocol at:

www.cms.hhs.gov/medicaid/managedcare/mceqrhmp.asp. The projects must be designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical and non-clinical areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction. Annually, the Contractor shall:

5.3.1.1. Implement a system of interventions to achieve improvement in quality.

5.3.1.2. Evaluate the effectiveness of the interventions.

5.3.1.3. Plan and initiate activities for increasing or sustaining improvement.

5.3.1.4. Report the status and results of each project to DSHS.

5.3.1.5. Complete projects in a reasonable time period as to allow aggregate information on the success of the projects to produce new information on the quality of care every year.

5.3.2. If any of the Contractor's Health Plan Employer Data and Information Set (HEDIS®) rates on Well Child Visits in the first 15 months (six (6) or more well child visits measure), Well Child Visits in the 3rd, 4th, 5th and 6th years of life, or Adolescent Well Care Visits are below 60%, the Contractor shall implement a DSHS approved clinical PIP designed to increase the rates. The Contractor may, at their option, count the required project toward meeting the requirement for at least three (3) clinical PIPs in Section 5.3.1.

5.3.3. If any of the Contractor's HEDIS® Childhood Immunization rates are below 65% in 2004 or below 70% in 2005, the Contractor shall implement a DSHS approved performance improvement project designed to increase the rates. The Contractor may, at their option, count the required project toward meeting the requirement for at least three (3) clinical PIPs in Section 5.3.1.

5.3.4. If the Contractor is below DSHS designated National CAHPS Benchmarking Database (NCBD) benchmarks, the Contractor's two non-clinical quality improvement projects shall be specified by DSHS, based upon the most current results of the Consumer Assessment of Health Plans (CAHPS) survey data for either children or adults. Benchmarks will be determined by DSHS and published annually.

5.3.5. In addition to the PIPs required under Sections 5.3.1 through 5.3.4., the Contractor shall participate in a yearly statewide quality assessment and performance improvement project or research project

designed by DSHS. The study shall be designed to maximize resources and reduce cost to contractors

5.4. **Independent Quality Review Organization (EQRO):** The Contractor shall allow a qualified External Quality Review Organization (EQRO), contracted by DSHS, to perform an annual external independent review as described in 42 CFR 438, Subpart E.

5.5. **CAHPS®:**

5.5.1. In 2004, the Contractor must create and submit the sampling frame file for the 2004 CAHPS Children and Children with Chronic Conditions Measurement set as specified by DSHS. A DSHS designated EQRO Contractor will conduct the Children and Children with Chronic Conditions survey based upon 2004 HEDIS Specifications for Survey Measures. DSHS or their designated EQRO will send file specifications and instructions to all Contractors regarding the format and other required information for the sample files by November 30, 2003. Contractors shall submit the eligible sample frames to DSHS's designated EQRO by January 30, 2004.

5.5.1.1. The Contractor shall contract with Certified HEDIS Auditor to validate the sample frame file and submit the certified audit letter (or compliance audit letter) to DSHS's designated EQRO by January 30, 2004.

5.5.1.2. DSHS' External Quality Review vendor will forward the Contractor's 2004 data to the National CAHPS Benchmarking Database (NCBD) based on the 2004 NCBD guidelines. Contractors will be responsible for filling out specific NCBD data submission forms as determined by DSHS and submitting those forms to DSHS's designated EQRO by June 30, 2004.

5.5.2. In 2005, the contractor is required to conduct a CAHPS® survey of adult Medicaid members enrolled in Healthy Options. The Contractor shall:

5.5.2.1. Ensure the survey sample frame consists of all non-Medicare and non-commercial adult plan members (not just subscribers) 18 years and older, as of December 31 of the measurement year, with Washington State addresses.

5.5.2.2. Contract with an NCQA certified vendor qualified to administer the CAHPS® survey and conduct the survey according to NCQA protocol.

5.5.2.3. The Contractor shall contract with a Certified HEDIS Auditor to validate the sample frame file and submit the certified audit letter (or compliance audit letter) to DSHS's designated EQRO by January 31, 2005.

5.5.2.4. Submit the following information to DSHS's designated EQRO:

5.5.2.4.1. Primary plan contact, vendor name and primary vendor contact.

5.5.2.4.2. Overall timeframe of vendor tasks

5.5.2.4.3. On a weekly basis - survey disposition reports and approximate response rates.

5.5.2.4.4. Final disposition report by June 30, 2005.

5.5.2.5. Conduct the mixed methodology (mail and phone surveys).

5.5.2.6. Submit a copy of the Washington State adult Medicaid response data set according to 2005 NCQA/CAHPS® standards to DSHS's designated External Quality Review vendor by June 30, 2005.

5.5.2.7. Submit a copy of the Washington State adult Medicaid response data set according to 2005 NCBD/CAHPS standards to DSHS's designated External Quality Review vendor by June 30, 2005.

5.5.2.8. DSHS' External Quality Review vendor will forward the Contractor's data to the NCBD based on the 2005 NCBD guidelines. Contractors will be responsible for filling out specific NCBD data submission forms as determined by DSHS and submitting those forms to DSHS's designated EQRO by June 30, 2005.

5.5.2.9. DSHS will determine the questionnaire format, questions and question placement, using the most recent HEDIS® version of the Medicaid adult questionnaire (currently 3.0H), plus approved supplemental and/or custom questions as determined by DSHS. Contractors will receive the approved DSHS questionnaire by January 31, 2005.

5.5.2.10. Contractors will be allowed up to seven Contractor supplemental questions with written approval from DSHS for amount, content, and placement prior to December 31, 2004.

5.5.2.11. Contractors are required to include performance guarantee language in their vendor subcontracts that require a vendor to achieve at least a 35% response rate.

5.5.3. If a Contractor cannot conduct the required annual CAHPS surveys (Children, Children with Chronic Conditions, or Adult) because of limited total enrollment and/or sample size, the Contractor shall notify DSHS in writing whether they have a physician or physician group at substantial financial risk in accordance with the physician incentive plan requirements under Section 8.8.

5.6. **Provider Education:** The Contractor shall maintain a system for keeping participating practitioners and providers informed about:

5.6.1. Covered services for enrollees served under this agreement;

5.6.2. Coordination of care requirements; and

5.6.3. DSHS policies as related to this agreement.

5.6.4. Interpretation of data from the quality improvement program (42 CFR 434.34(d)).

5.7. **Claims Payment Standards:** The Contractor shall meet the timeliness of payment standards specified for Medicaid fee-for-service in Section 1902(a)(37)(A) of the Social Security Act and specified for health carriers in WAC 284-43-321. To be compliant with both payment standards the Contractor shall pay or deny, and shall require subcontractors to pay or deny, 95% of clean claims within thirty (30) calendar days of receipt, 95% of all claims within sixty (60) of receipt and 99% of clean claims within ninety (90) calendar days of receipt. The Contractor and its providers may agree to a different payment requirement in writing on an individual claim.

5.7.1. A claim is a bill for services, a line item of service or all services for one enrollee within a bill.

5.7.2. A clean claim is a claim that can be processed without obtaining additional information from the provider of the service or from a third party.

5.7.3. The date of receipt is the date the Contractor receives the claim from the provider.

5.7.4. The date of payment is the date of the check or other form of payment.

5.8. **Health Insurance Portability and Accountability Act (HIPAA)**: The Contractor and the Contractor's subcontractors shall comply with the applicable provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, codified at 42 USC 1320(d) et.seq. and 45 CFR parts

160, 162, and 164. The Contractor and the Contractor's subcontractors shall fully cooperate with DSHS efforts to implement HIPAA requirements.

5.9. **Practice Guidelines:** The Contractor shall adopt practice guidelines that meet the following requirements (42 CFR 438.6):

5.9.1. Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field.

5.9.2. Consider the needs of enrollees.

5.9.3. Are adopted in consultation with contracting health care professionals.

5.9.4. Are reviewed and updated periodically as appropriate.

5.9.5. Are disseminated to all affected providers and, upon request, to DSHS, enrollees and potential enrollees.

5.9.6. Are the basis for and are consistent with decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply.

5.10. **Advance Directives:**

5.10.1. The Contractor shall maintain written policies and procedures for advance directives that meet the requirements of WAC 388-501-0125, 42 CFR 438.6, 42 CFR 438.10, 42 CFR 422.128, and 42 CFR 489 Subpart I. The Contractor's advance directive policies and procedure shall be disseminated to all affected providers, enrollees, DSHS, and, upon request, potential enrollees.

5.10.2. The Contractor's written policies respecting the implementation of advance directive rights shall include a clear and precise statement of limitation if the Contractor cannot implement an advance directive as a matter of conscience. At a minimum, this statement must do the following:

5.10.2.1. Clarify any differences between Contractor conscientious objections and those that may be raised by individual physicians.

5.10.2.2. Identify the state legal authority permitting such objection.

5.10.2.3. Describe the range of medical conditions or procedures affected by the conscience objection.

5.10.3. If an enrollee is incapacitated at the time of initial enrollment and is unable to receive information (due to the incapacitating condition or a mental disorder) or articulate whether or not he or she has executed an advance directive, the Contractor may give advance directive information to the enrollee's family or surrogate in the same manner that it issues other materials about policies and procedures to the family of the incapacitated enrollee or to a surrogate or other concerned persons in accord with State law. The Contractor is not relieved of its obligation to provide this information to the enrollee once he or she is no longer incapacitated or unable to receive such information. Follow-up procedures must be in place to ensure that the information is given to the individual directly at the appropriate time.

5.10.4. The Contractor's policies and procedures must require, and the Contractor must ensure, that the enrollee's medical record documents, in a prominent part, whether or not the individual has executed an advance directive.

5.10.5. The Contractor shall not condition the provision of care or otherwise discriminate against an enrollee based on whether or not the enrollee has executed an advance directive.

5.10.6. The Contractor shall ensure compliance with requirements of State and Federal law (whether statutory or recognized by the courts of the State) regarding advance directives.

5.10.7. The Contractor shall provide for education of staff concerning its policies and procedures on advance directives.

5.10.8. The Contractor shall provide for community education regarding advance directives that may include material required herein, either directly or in concert with other providers or entities. Separate community education materials may be developed and used, at the discretion of the Contractor. The same written materials are not required for all settings, but the material should define what constitutes an advance directive, emphasizing that an advance directive is designed to enhance an incapacitated individual's control over medical treatment, and describe applicable State and Federal law concerning advance directives. The Contractor shall document its community education efforts.

5.10.9. The Contractor is not required to provide care that conflicts with an advance directive; and is not required to implement an advance directive if, as a matter of conscience, the Contractor cannot implement an advance directive and State law allows the Contractor or

any subcontractor providing services under this agreement to conscientiously object.

5.10.10. The Contractor shall inform enrollees that they may file a grievance with the Contractor if the enrollee is dissatisfied with the Contractor's advance directive policy and procedure or the Contractor's administration of those policies and procedures. The Contractor shall also inform enrollees that they may file a grievance with DSHS if they believe the Contractor is non-compliant with advance directive requirements.

5.11. **Health Information Systems:** The Contractor shall maintain and shall require subcontractors to maintain a health information system that complies with the requirements of 42 CFR 438.242 and provides the information necessary to meet the Contractor's obligations under this agreement. The Contractor shall have in place mechanisms to verify the health information received from subcontractors. Mechanisms shall include the following:

5.11.1. A health information system that collects, analyze, integrates, and reports data. The system must provide information on areas including but not limited to, utilization, grievance, and appeals, and disenrollments for other than loss of Medicaid eligibility.

5.11.2. Data received from providers is accurate and complete by:

5.11.2.1. Verifying the accuracy and timeliness of reported data;

5.11.2.2. Screening the data for completeness, logic, and consistency; and

5.11.2.3. Collecting service information on standardized formats to the extent feasible and appropriate.

5.11.3. The Contractor shall make all collected data available to DSHS and The Center for Medicare and Medicaid Services (CMS) upon request.

6. **REPORTING REQUIREMENTS:**

6.1. **Certification Requirements:** Any information and/or data required by this agreement and identified by DSHS as requiring certification shall be certified by the Contractor as follows (42 CFR 438.600 through 42 CFR 438.606):

6.1.1. Source of certification: The information and/or data shall be certified by one of the following:

6.1.1.1. The Contractor's Chief Executive Officer

6.1.1.2. The Contractor's Chief Financial Officer

6.1.1.3. An individual who has delegated authority to sign for, and who reports directly to, the Contractor's Chief Executive Officer or Chief Financial Officer

6.1.2. Content of certification: The Contractor's certification shall attest, based on best knowledge, information, and belief, to the accuracy, completeness and truthfulness of the information and/or data.

6.1.3. Timing of certification: The Contractor shall submit the certification concurrently with the certified information and/or data.

6.2. **HEDIS® Measures:** In accordance with 7.5 Notices, the Contractor shall report to DSHS, the following HEDIS® measures using the current HEDIS® Technical Specifications and official corrections published by NCQA, unless directed otherwise in writing by DSHS.

6.2.1. No later than June 15th of each year, the following HEDIS® measures shall be submitted electronically to DSHS and a second copy shall be submitted to the EQRO designated by DSHS, using the NCQA data submission tool (DST):

6.2.1.1. Childhood Immunization Status

6.2.1.2. Prenatal and Postpartum Care

6.2.1.3. Well Child Visits in the First 15 Months of Life

6.2.1.4. Well Child Visits in the Third, Fourth, Fifth and Sixth Years of Life

6.2.1.5. Adolescent Well Child Visits

6.2.1.6. Use of Appropriate Medications for People with Asthma

6.2.1.7. Comprehensive Diabetes Care

6.2.1.8. Inpatient Utilization-General Hospital/Acute Care

6.2.1.9. Ambulatory Care

6.2.1.10. Birth and Average Length of Stay, Newborns

6.2.2. All measures shall be audited, at Contractor expense, by an NCQA licensed organization in accord with the current HEDIS COMPLIANCE AUDIT™ standards, policies and procedures. The signed and certified audit report shall be submitted to DSHS no later than July 15th of each year. A second copy shall be submitted to the EQRO designated by DSHS.

6.2.2.1. If the Contractor has current NCQA accreditation, including Medicaid, a full audit, as defined by NCQA, is allowed.

6.2.2.2. If the Contractor does not have current NCQA accreditation, including Medicaid, a partial audit, as defined by NCQA, must be conducted.

6.2.3. The Contractor may rotate HEDIS® measures only with the advance written permission of DSHS. The Contractor may request permission to rotate measures by making a written request to the DSHS contact named in the Notices section of this agreement.

6.3. **Encounter Data:**

6.3.1. Encounter data includes all services delivered to enrollees. DSHS collects and uses this data for many reasons such as: federal reporting; rate setting and risk adjustment; managed care quality improvement program, utilization patterns and access to care; DSHS hospital rate setting; and research studies. The Contractor shall comply with the Encounter Data Guide for Managed Care Organizations published by DSHS.

6.3.2. DSHS may change the Encounter Data Guide for Managed Care Organizations with one hundred and fifty (150) calendar days written notice to the Contractor. The Encounter Data Guide for Managed Care Organizations may be changed with less than one hundred and fifty (150) calendar days notice by mutual agreement of the Contractor and DSHS. The Contractor shall, upon receipt of such notice from DSHS, provide notice of changes to subcontractors.

6.4. **Integrated Provider Network Database (IPND):** The Contractor shall report their complete provider network, to include all current contracted providers, monthly to DSHS through the designated data management contact in accord with the Provider Network Reporting Requirements published by DSHS at http://maa.dshs.wa.gov/healthyoptions/IPND.

6.5. **FQHC/RHC Report:** The Contractor shall provide DSHS with information related to subcontracted federally-qualified health centers (FQHC) and rural

health clinics (RHC), as required by the DSHS Healthy Options Licensed Health Carrier Billing Instructions, published by DSHS.

6.6. **Enrollee Mortality:** The Contractor shall maintain a record of known enrollee deaths, including the enrollee's name, date of birth, age at death, location of death, and cause(s) of death. This information shall be available to DSHS upon request. The Contractor shall assist DSHS in efforts to evaluate and improve the availability and utility of selected mortality information for quality improvement purposes.

6.7. **Actions, Grievances and Appeals:** The Contractor shall maintain a record of all actions, grievances and appeals, including actions, grievances and appeals handled by a delegated entity and independent review of adverse decisions by an independent review organization. The Contractor shall provide a report of complete actions, grievances and appeals to DSHS biannually for the prior six months. The report for the six months ending March 31st is due no later than June 1st and the report for the six months ending September 30th is due no later than November 1st. The Contractor is responsible for maintenance of records for and reporting of any grievance, actions and appeals handled by delegated entities. Delegated actions, grievances and appeals are to be integrated into the Contractor's report. Data shall be reported in the DSHS and Contractor agreed upon format. The report medium shall be specified by DSHS. Reporting of actions shall include all denials or limited authorization of a requested service, including the type or level of service, and the reduction, suspension, or termination of a previously authorized service but will not include denials of payment to providers. Reporting of grievances shall include all expressions of enrollee dissatisfaction not related to an action. The records shall be sorted using the sort keys identified and shall include, at a minimum:

6.7.1. Name of Program: HO, CHIP, or BH+ (Primary Sort Key)

6.7.2. Name of the delegated entity, if any

6.7.3. Enrollee Identifier (three separate fields):

6.7.3.1. Patient Identification Code (PIC) (preferred) or

6.7.3.2. Enrollee Name and Enrollee Birthday: If PIC not reported

6.7.4. Name of Practitioner (Optional)

6.7.5. Type of Practitioner (Optional)

6.7.6. Type (Secondary Sort Key):

6.7.6.1. Action

6.7.6.2. Grievance

6.7.6.3. Appeal - First Level

6.7.6.4. Appeal - Second Level

6.7.6.5. IRO

6.7.7. Expedited: Yes or No

6.7.8. Grievance, Appeal or IRO Issue

6.7.9. Category of Action or Grievance

6.7.10. Action Reason

6.7.11. Resolution of Grievance, Appeal or IRO

6.7.12. Action Date

6.7.13. Receipt Date of Grievance, Appeal or IRO

6.7.14. Date of Resolution of Grievance, Appeal, or IRO

6.7.15. Date written notification of Action or Grievance, Appeal or IRO outcome sent to enrollee and practitioner

6.8. **Drug Formulary Review and Approval:** The Contractor shall submit its drug formulary, for use with enrollees covered under the terms of this agreement, to DSHS for review and approval by January 31st of each year of this agreement.

6.9. **Fraud and Abuse:** The Contractor shall report in writing all verified cases of fraud and abuse, including fraud and abuse by the Contractor's employees and subcontractors, within seven (7) calendar days to DSHS according to Section 7.5, Notices. The report shall include the following information:

6.9.1. Subject(s) of complaint by name and either provider/subcontractor type or employee position.

6.9.2. Source of complaint by name and provider/subcontractor type or employee position, if applicable.

6.9.3. Nature of complaint.

6.9.4. Estimate of the amount of funds involved.

6.9.5. Legal and administrative disposition of case.

6.10. **Five Percent Equity:** The Contractor shall provide the DSHS, MAA, Division of Program Support, Contract Manager assigned to the Contractor a list of persons with a beneficial ownership of more than 5% of the Contractor's equity no later than February 28th of each year of this agreement.

7. GENERAL TERMS AND CONDITIONS

7.1. **Complete Agreement:** This agreement incorporates Exhibits to this agreement and the DSHS billing instructions applicable to the Contractor. All terms and conditions of this agreement are stated in this agreement and its incorporations. No other agreements, oral or written, are binding.

7.2. **Modification:** This agreement may only be modified by mutual consent of the parties. All modifications shall be set forth in contract amendments issued by DSHS.

7.3. **Waiver:** The failure of either party to enforce any provision of this agreement shall not constitute a waiver of that or any other provision, and will not be construed to be a modification of the terms and conditions of the agreement unless incorporated into the agreement with an amendment.

7.4. **Limitation of Authority:** No alteration, modification, or waiver of any clause or condition of the agreement is binding unless made in writing and signed by a DSHS Contracting Officer or their designee.

7.5. **Notices:** Whenever one party is required to give notice to the other under this agreement, it shall be deemed given if mailed by United States Postal Service, registered or certified mail, return receipt requested, postage prepaid and addressed as follows:

In the case of notice to the Contractor, notice will be sent to the point of contact identified on the signature page of the agreement.

In the case of notice to DSHS:

Peggy Wilson, Section Manager (or her successor)
Managed Care Contract Management Section
Division of Program Support
Medical Assistance Administration
Department of Social and Health Services
P.O. Box 45530
Olympia, WA 98504-5530

Said notice shall become effective on the date delivered as evidenced by the return receipt or the date returned to the sender for non-delivery other than for insufficient postage. Either party may at any time change its address for notification purposes by mailing as aforesaid a notice stating the change and setting forth the new address, which shall be effective on the tenth day following the effective date of such notice unless a later date is specified.

7.6. **Force Majeure:** If the Contractor is prevented from performing any of its obligations hereunder in whole or in part as a result of a major epidemic, act of God, war, civil disturbance, court order, or any other cause beyond its control, such nonperformance shall not be a ground for termination for default. Immediately upon the occurrence of any such event, the Contractor shall commence to use its best efforts to provide, directly or indirectly, alternate and, to the extent practicable, comparable performance. Nothing in this clause shall be construed to prevent DSHS from terminating this agreement for reasons other than for default during the period of events set forth above, or for default, if such default occurred prior to such event.

7.7. **Sanctions:**

7.7.1. DSHS will notify the Contractor in writing of the basis and nature of the any sanctions and, if applicable, provide a reasonable deadline for curing the cause for the sanction before imposing sanctions. The Contractor may request a dispute resolution, as described in Section 7.23, Disputes, if the Contractor disagrees with DSHS' position.

7.7.2. When the Contractor fails to meet its obligations under the terms of this agreement, DSHS may impose sanctions by withholding up to five percent of payments to the Contractor rather than terminating the agreement.

DSHS may withhold payment from the end the cure period until the default is cured or any resulting dispute is resolved in the Contractor's favor.

7.7.3. DSHS, CMS or the Office of the Inspector General (OIG) may impose intermediate sanctions, in accord with 42 CFR 438.700, 42 CFR 438.702, 42 CFR 438.704, 45 CFR 92.36(i)(1), 42 CFR 422.208 and 42 CFR 422.210, against the Contractor for:

7.7.3.1. Failing to provide medically necessary services that the Contractor is required to provide, under law or under this agreement, to an enrollee covered under this agreement.

7.7.3.2. Imposing on enrollees premiums or charges that are in excess of the premiums or charges permitted under law or under this agreement.

7.7.3.3. Acting to discriminate among enrollees on the basis of their health status or need for health care services. This includes termination of enrollment or refusal to reenroll a recipient, except as permitted under law or under this agreement, or any practice that would reasonably be expected to discourage enrollment by recipients whose medical condition or history indicates probable need for substantial future medical services.

7.7.3.4. Misrepresenting or falsifying information that it furnishes to CMS or to the State.

7.7.3.5. Misrepresenting or falsifying information that it furnishes to an enrollee, potential enrollee, or health care provider.

7.7.3.6. Failing to comply with the requirements for physician incentive plans.

7.7.3.7. Distributing directly, or indirectly through any agent or independent contractor, marketing materials that have not been approved by the State or that contain false or materially misleading information.

7.7.3.8. Violating any of the other requirements of Sections 1903(m) or 1932 of the Social Security Act, and any implementing regulations.

7.7.3.9. Intermediate sanctions may include:

7.7.3.9.1. Civil monetary penalties in the following amounts:

7.7.3.9.1.1. A maximum of $25,000 for each determination of failure to provide services; misrepresentation or false statements to enrollees, potential enrollees or healthcare providers; failure to comply with physician incentive plan requirements; or marketing violations.

7.7.3.9.1.2. A maximum of $100,000 for each determination of discrimination; or misrepresentation or false statements to CMS or the State.

7.7.3.9.1.3. A maximum of $15,000 for each potential enrollee DSHS determines was not enrolled because of a discriminatory practice subject to the $100,000 overall limit.

7.7.3.9.1.4. A maximum of $25,000 or double the amount of the charges, whichever is greater, for charges to enrollees that are not allowed under HO or SCHIP. DSHS will deduct from the penalty the amount charged and return it to the enrollee.

7.7.3.9.2. Appointment of temporary management for the Contractor as provided in 42 CFR 438.706. DSHS will only impose temporary management if it finds that the Contractor has repeatedly failed to meet substantive requirements in Sections 1903(m) or 1932 of the Social Security Act. Either DSHS or the Contractor may terminate this agreement, as otherwise provided herein, prior to and as an alternative to appointment of temporary management.

7.7.3.9.3. Suspension of all new enrollment, including default enrollment, after the effective date of the sanction.

7.7.3.9.4. Suspension of payment for enrollees enrolled after the effective date of the sanction and until CMS or DSHS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

7.8. **Assignment of this Agreement:** This agreement, including the rights, benefits, and duties herein, shall be binding on the parties and their successors and assignees but shall not be assignable by either party without the express written consent of the other. Nor shall any claim, pertinent to this agreement, against one of the parties be assignable without the express written consent of the other.

7.9. **Headings Not Controlling:** The headings and the index used herein are for reference and convenience only, and shall not enter into the interpretation thereof, or describe the scope or intent of any provisions or sections of this agreement.

7.10. **Order of Precedence:** In the interpretation of this agreement and incorporated documents, the various terms and conditions shall be construed as much as possible to be complementary. In the event that such interpretation is not possible the following order of precedence shall apply:

7.10.1. Federal statutes and regulations concerning the operation of Health Maintenance Organizations and the provisions of Title XIX of the federal Social Security Act.

7.10.2. State of Washington statutes and regulations concerning the operation of the DSHS' Medical Assistance Program, including but not limited to WAC 388-538.

7.10.3. State of Washington statutes and regulations concerning the operation of Health Maintenance Organizations and Health Care Service Contractors.

7.10.4. The terms and conditions of this agreement.

7.11. **Proprietary Rights:** DSHS recognizes that nothing in this agreement shall give DSHS rights to the systems developed or acquired by the Contractor during the performance of this agreement. The Contractor recognizes that nothing in this agreement shall give the Contractor rights to the systems developed or acquired by DSHS during the performance of this agreement.

7.12. **Covenant Against Contingent Fees:** The Contractor promises that no person or agency has been employed or retained on a contingent fee for the purpose of seeking or obtaining this agreement. This does not apply to legitimate employees or an established commercial or selling agency maintained by the Contractor for the purpose of securing business. In the event of breach of this clause by the Contractor DSHS may at its discretion: a) annul the agreement without any liability; or b) deduct from the agreement price or consideration or otherwise recover the full amount of any such contingent fee.

7.13. **Enrollees' Right to Obtain a Conversion Agreement:** The Contractor shall offer a conversion agreement to all enrollees whose enrollment is terminated due to loss of eligibility for Medical Assistance in accord with RCW 48.46.450.

7.14. **Records Maintenance and Retention:**

7.14.1. **Maintenance:** The Contractor and its subcontractors shall maintain financial, medical and other records pertinent to this agreement. All financial records shall follow generally accepted accounting principles. Medical records and supporting management systems shall include all pertinent information related to the medical management of each enrollee. Other records shall be maintained as necessary to clearly reflect all actions taken by the Contractor related to this agreement.

7.14.2. **Retention:** All records and reports relating to this agreement shall be retained by the Contractor and its subcontractors for a minimum of seven (7) years after final payment is made under this agreement or, in the event that this agreement is renewed, seven (7) years after the renewal date. However, when an audit, litigation, or other action

involving records is initiated prior to the end of said period, records shall be maintained for a minimum of seven (7) years following resolution of such action.

7.15. **Access to Facilities and Records:** The Contractor and its subcontractors shall cooperate with medical and financial audits performed by duly authorized representatives of DSHS, the state of Washington Auditor's Office, DHHS, and federal auditors from the United States government General Accounting Office and the Office of Management and Budget. With reasonable notice, generally thirty (30) calendar days, the Contractor and its subcontractors shall provide access to its facilities and the financial and medical records pertinent to this agreement to monitor and evaluate performance under this agreement, including, but not limited to, the quality, cost, use and timeliness of services (42 CFR 434.52), and assessment of the Contractor's capacity to bear the potential financial losses (42 CFR 434.58). The Contractor and its subcontractors shall provide immediate access to facilities and records pertinent to this agreement for Medicaid fraud investigators.

7.16. **Solvency:**

7.16.1. The Contractor shall have a Certificate of Registration as either a Health Maintenance Organization or a Health Care Service Contractor from the Office of the Insurance Commissioner (OIC). The Contractor shall comply with the solvency provisions of RCW 48.44 or RCW 48.46, as amended.

7.16.2. The Contractor shall notify DSHS immediately upon being notified by OIC that they are to report financial information quarterly or monthly and provide DSHS with the same information provided to OIC in response to any OIC request. The Contractor shall deliver all required information and notices to DSHS at the address listed in 7.5 Notices. The Contractor agrees that DSHS may at anytime access any information related to the Contractor's financial condition, or compliance with OIC requirements, from OIC and consult with OIC concerning such information.

7.16.3. The Contractor shall provide DSHS with the Contractor's audited financial statements as soon as they become available to the Contractor. Financial statements shall be delivered to the address list in 7.5 Notices.

7.16.4. If the Contractor becomes insolvent during the term of this agreement:

7.16.4.1. The state of Washington and enrollees shall not be in any manner liable for the debts and obligations of the Contractor.

7.16.4.2. In accord with Section 10.13 Prohibition on Enrollee Charges for Covered Services, under no circumstances shall the Contractor, or any providers used to deliver services covered under the terms of this agreement, charge enrollees for covered services.

7.16.4.3. The Contractor shall, in accord with RCW 48.44.055 or RCW 48.46.245, provide for the continuity of care for enrollees.

7.17. **Compliance with All Applicable Laws and Regulations:** In the provision of services under this agreement, the Contractor and its subcontractors shall comply with all applicable federal and state statutes and regulations, and all amendments thereto, that are in effect when the agreement is signed or that come into effect during the term of the agreement (42 CFR 438.100(d). This includes, but is not limited to:

7.17.1. Title XIX and Title XXI of the Social Security Act.

7.17.2. Title VI of the Civil Rights Act of 1964.

7.17.3. Title IX of the Education Amendments of 1972, regarding any education programs and activities.

7.17.4. The Age Discrimination Act of 1975.

7.17.5. The Rehabilitation Act of 1973

7.17.6. The Americans with Disabilities Act.

7.17.7. All applicable OIC statutes and regulations.

7.17.8. All local, state, and federal professional and facility licensing and accreditation requirements/standards that apply to services performed under the terms of this agreement, including but not limited to:

7.17.8.1. All applicable standards, orders, or requirements issued under Section 306 of the Clean Air Act (42 US 1857(h)), Section 508 of the Clean Water Act (33 US 1368), Executive Order 11738, and Environmental Protection Agency (EPA) regulations (40 CFR Part 15), which prohibit the use of facilities included on the EPA List of Violating Facilities. Any violations shall be reported to DSHS, DHHS, and the EPA.

7.17.8.2. Any applicable mandatory standards and policies relating to energy efficiency that are contained in the State Energy

Conservation Plan, issued in compliance with the federal Energy Policy and Conservation Act.

7.17.8.3. Those specified for laboratory services in the Clinical Laboratory Improvement Amendments (CLIA).

7.17.8.4. Those specified in Title 18 for professional licensing.

7.17.9. Liability insurance requirements.

7.17.10. Reporting of abuse as required by RCW 26.44.030.

7.17.11. Industrial insurance coverage as required by Title 51 RCW.

7.17.12. Any other requirements associated with the receipt of federal funds.

7.18. **Nondiscrimination:** The Contractor shall comply with all federal and state nondiscrimination laws and regulations.

7.19. **Review of Client Information:** DSHS agrees to provide the Contractor with written client information, which DSHS intends to distribute to all or a class of clients.

7.20. **Contractor Not Employee of DSHS:** The Contractor acknowledges and certifies that its directors, officers, partners, employees, and agents are not officers, employees, or agents of DSHS or the state of Washington. The Contractor shall not hold itself out as or claim to be an officer, employee, or agent of DSHS or the state of Washington by reason of this agreement. The Contractor shall not claim any rights, privileges, or benefits that would accrue to a civil service employee under RCW 41.06.

7.21. **DSHS Not Guarantor:** The Contractor acknowledges and certifies that neither DSHS nor the state of Washington are guarantors of any obligations or debts of the Contractor.

7.22. **Mutual Indemnification and Hold Harmless:** The parties shall be responsible for and shall indemnify and hold each other harmless from all claims and/or damages to persons and/or property resulting from its negligent acts and omissions. The Contractor shall indemnify and hold harmless DSHS from any claims by non-participating providers related to the provision to enrollees of covered services under this agreement.

7.23. **Disputes:** When a dispute arises over an issue concerning the terms of the agreement, the parties agree to the following process to address the dispute:

7.23.1. The Contractor and DSHS shall attempt to resolve the dispute through informal means between the Contractor and the DSHS, MAA, Division of Program Support, Contract Manager assigned to the Contractor.

7.23.2. If the Contractor is not satisfied with the outcome of the resolution with the Contract Manager, the Contractor may submit the disputed issue, in writing, for review, within ten (10) working days of the outcome, to:

MaryAnne Lindeblad, Director (or her successor)
Division of Program Support
Medical Assistance Administration
Department of Social and Health Services
P.O. Box 45530
Olympia, WA 98504-5530

The Director may request additional information from the Contract Manager and/or the Contractor. The Director shall issue a written review decision to the Contractor within thirty (30) calendar days of receipt of all information relevant to the issue. The review decision will be provided to the Contractor according to Section 7.5.

7.23.3. When the Contractor disagrees with the review decision of the Director, the Contractor may request independent mediation of the dispute. The request for mediation must be submitted to the Director, in writing, within ten (10) working days of the Contractor's receipt of the Director's review decision. The Contractor and DSHS shall mutually agree on the selection of the independent mediator and shall bear all costs associated with mediation equally. The results of mediation shall not be binding on either party.

7.23.4. Both parties agree to make their best efforts to resolve disputes arising from this agreement and agree that the dispute resolution process described herein shall precede any court action. This dispute resolution process is the sole administrative remedy available under this agreement.

7.24. **Governing Law and Venue:** The laws of the state of Washington shall govern this agreement. In the event of a lawsuit involving this agreement, venue shall be proper only in Thurston County, Washington. By execution of this agreement, the Contractor acknowledges the jurisdiction of the courts of the state of Washington regarding this matter.

7.25. **Severability:** If any provision of this agreement, including any provision of any document incorporated by reference, shall be held invalid, that invalidity shall not affect the other provisions of the agreement. To that end, the provisions of this agreement are declared to be severable.

7.26. **Excluded Persons:**

7.26.1. The Contractor may not knowingly have a director, officer, partner, or person with a beneficial ownership of more than 5% of the Contractor's equity, or have an employee, consultant or contractor who is significant or material to the provision of services under this agreement, who has been, or is affiliated with someone who has been, debarred, suspended, or otherwise excluded by any federal agency (SSA 1932(d)(1)). A list of excluded parties is available on the following Internet website: www.arnet.gov/epls.

7.26.2. By entering into this agreement, the Contractor certifies that it does not knowingly have anyone who is an excluded person, or is affiliated with an excluded person, as a director, officer, partner, employee, contractor, or person with a beneficial ownership of more than 5% of its equity. The Contractor is required to notify DSHS when circumstances change that affect such certification.

7.26.3. The Contractor is not required to consult the excluded parties list, but may instead rely on certifications from directors, officers, partners, employees, contractors, or persons with beneficial ownership of more than 5% of the Contractor's equity, that they are not debarred or excluded from a federal program.

7.27. **Fraud and Abuse Requirements - Policies and Procedures:**

7.27.1. The Contractor shall have administrative and management arrangements or procedures, and a mandatory compliance plan, that are designed to guard against fraud and abuse (42 CFR 438.608(a)).

7.27.2. The Contractor's arrangements or procedures shall include the following (42 CFR 438.608(b)(1)):

7.27.2.1. Written policies, procedures, and standards of conduct that articulates the Contractor's commitment to comply with all applicable Federal and State standards.

7.27.2.2. The designation of a compliance officer and a compliance committee that are accountable to senior management.

7.27.2.3. Effective training for the compliance officer and the Contractor's employees.

7.27.2.4. Effective lines of communication between the compliance officer and the Contractor's staff.

7.27.2.5. Enforcement of standards through well-publicized disciplinary guidelines.

7.27.2.6. Provision for internal monitoring and auditing.

7.27.2.7. Provision for prompt response to detected offenses, and for development of corrective action initiatives.

7.27.3. The Contractor shall submit a written copy of its administrative and management arrangements or procedures and mandatory compliance plan regarding fraud and abuse to DSHS for approval, according to Section 7.5, Notices, by March 31st each year of this agreement. DSHS shall respond with approval or denial with required modifications within thirty (30) calendar days of receipt. The Contractor shall have thirty (30) calendar days to resubmit the policies and procedures.

7.27.4. The Contractor may request a copy of the guidelines that DSHS will use in evaluating the Contractor's written administrative and management arrangements or procedures and mandatory compliance plan regarding fraud and abuse, and may request technical assistance in preparing the written administrative and management arrangements or procedures and mandatory compliance plan regarding fraud and abuse, by contacting the DSHS, MAA, Division of Program Support Contract Manager assigned to the Contractor.

7.28. **Insurance:** The Contractor shall at all times comply with the following insurance requirements.

7.28.1. Commercial General Liability Insurance (CGL): The Contractor shall maintain Commercial General Liability Insurance, including coverage for bodily injury, property damage, and contractual liability, with the following minimum limits: Each Occurrence - $1,000,000; General Aggregate - $2,000,000. The policy shall include liability arising out of premises, operations, independent contractors, products-completed operations, personal injury, advertising injury, and liability assumed under an insured contract. The state of Washington, DSHS, its elected and appointed officials, agents, and employees shall be named as additional insureds expressly for, and limited to, Contractor's services provided under this contract.

7.28.2. Professional Liability Insurance (PL): If the Contractor provides professional services, either directly or indirectly, the Contractor shall maintain Professional Liability Insurance, including coverage for losses caused by errors and omissions, with the following minimum

limits: Each Occurrence - $1,000,000; General Aggregate - $2,000,000.

7.28.3. Worker's Compensation: The Contractor shall comply with all applicable worker's compensation, occupational disease, and occupational health and safety laws and regulations. The state of Washington and DSHS shall not be held responsible as an employer for claims filed by the Contractor or its employees under such laws and regulations.

7.28.4. Employees and Volunteers: Insurance required of the Contractor under the Contract shall include coverage for the acts and omissions of the Contractor's employees and volunteers.

7.28.5. Subcontractors: The Contractor shall ensure that all subcontractors have and maintain insurance appropriate to the services to be performed. The Contractor shall make available copies of Certificates of Insurance for subcontractors, to DSHS if requested.

7.28.6. Separation of Insureds: All insurance Commercial General Liability policies shall contain a "separation of insureds" provision.

7.28.7. Insurers: The Contractor shall obtain insurance from insurance companies authorized to do business within the state of Washington, with a "Best's Reports" rating of A-, Class VII or better. Any exception must be approved by the DSHS. Exceptions include placement with a "Surplus Lines" insurer or an insurer with a rating lower than A-, Class VII.

7.28.8. Evidence of Coverage: The Contractor shall submit Certificates of Insurance to the DSHS Central Contract Services, Insurance Services, PO Box 45811, Olympia, Washington 98504-5811, for each coverage required of the Contractor under the Contract no later than January 15, 2004 DSHS in accord with the Notices section of this agreement. Each Certificate of Insurance shall be executed by a duly authorized representative of each insurer.

7.28.9. Material Changes: The Contractor shall give DSHS, in accord with the Notices section of this agreement, 45 days advance notice of cancellation or non-renewal of any insurance in the Certificate of Coverage. If cancellation is due to non-payment of premium, the Contractor shall give DSHS 10 days advance notice of cancellation.

7.28.10. General: By requiring insurance, the state of Washington and DSHS do not represent that the coverage and limits specified will be adequate to protect the Contractor. Such coverage and limits shall not

be construed to relieve the Contractor from liability in excess of the required coverage and limits and shall not limit the Contractor's liability under the indemnities and reimbursements granted to the State and DSHS in this Contract. All insurance provided in compliance with this Contract shall be primary as to any other insurance or self-insurance programs afforded to or maintained by the State.

7.28.11. Contractor may waive the requirements contained in 7.28.1, 7.28.2, 7.28.7, and 7.28.8, if self-insured. In the event the Contractor is self insured, the Contractor must send to DSHS by January 15, 2004, a signed written document, which certifies that the contractor is self insured, carries coverage adequate to meet the requirements of section 7.28, will treat DSHS as an additional insured, expressly for, and limited to, the Contractor's services provided under this Contract, and provides a point of contact for DSHS.

8. **SUBCONTRACTS**

8.1. **Contractor Remains Legally Responsible:** Subcontracts, as defined herein, may be used by the Contractor for the provision of any service under this agreement. However, no subcontract shall terminate the Contractor's legal responsibility to DSHS for any work performed under this agreement (42 CFR 434.6 (c)).

8.2. **Solvency Requirements for Subcontractors:** For any subcontractor at financial risk, as described in Section 8.8.3. Substantial Financial Risk, or 1.17. Risk, the Contractor shall establish, enforce and monitor solvency requirements that provide assurance of the subcontractor's ability to meet its obligations.

8.3. **Required Provisions:** Subcontracts shall be in writing, consistent with the provisions of 42 CFR 434.6. All subcontracts shall contain the following provisions:

8.3.1. Identification of the parties of the subcontract and their legal basis for operation in the state of Washington.

8.3.2. Procedures and specific criteria for terminating the subcontract.

8.3.3. Identification of the services to be performed by the subcontractor and which of those services may be subcontracted by the subcontractor.

8.3.4. Reimbursement rates and procedures for services provided under the subcontract.

8.3.5. Release to the Contractor of any information necessary to perform any of its obligations under this agreement.

8.3.6. Reasonable access to facilities and financial and medical records for duly authorized representatives of DSHS or DHHS for audit purposes, and immediate access for Medicaid fraud investigators.

8.3.7. The requirement to completely and accurately report encounter data to the Contractor. Contractor shall ensure that all subcontractors required to report encounter data have the capacity to comply with the Encounter Data Submission Requirements, Exhibit C-1.

8.3.8. The requirement to comply with the Contractor's DSHS approved fraud and abuse policies and procedures.

8.3.9. No assignment of the subcontract shall take effect without the DSHS' written agreement.

8.3.10. The subcontractor shall comply with the applicable state and federal rules and regulations as set forth in this agreement, including the applicable requirements of 42 CFR 438.6.

8.3.11. Subcontracts shall set forth and require the subcontractor to comply with any term or condition of this agreement that is applicable to the services to be performed under the subcontract.

8.3.12. The Contractor shall provide the following information regarding the grievance system to all subcontractors at the time that they enter into a contract or no later than January 15, 2004 for continuing subcontractors (42 CFR 438.414 and 42 CFR 438.10(g)(1)):

8.3.12.1. The enrollee's right to a fair hearing, how to obtain a hearing, and representation rules at a hearing.

8.3.12.2. The enrollee's right to file grievances and appeals and their requirements and timeframes for filing.

8.3.12.3. The availability of assistance in filing.

8.3.12.4. The toll-free numbers to file oral grievances and appeals.

8.3.12.5. The enrollee's right to request continuation of benefits during an appeal or fair hearing and, if the Contractor's action is upheld, the enrollee's responsibility to pay for the continued benefits.

8.4. **Health Care Provider Subcontracts**, including those for facilities, shall also contain the following provisions:

8.4.1. A quality improvement system tailored to the nature and type of services subcontracted, which affords quality control for the health care provided, including but not limited to the accessibility of medically necessary health care, and which provides for a free exchange of information with the Contractor to assist the Contractor in complying with the requirements of this agreement.

8.4.2. A means to keep records necessary to adequately document services provided to enrollees.

8.4.3. Information about enrollees, including their medical records, shall be kept confidential in a manner consistent with state and federal laws and regulations.

8.4.4. The subcontractor accepts payment from the Contractor as payment in full and shall not request payment from DSHS or any enrollee for covered services performed under the subcontract.

8.4.5. The subcontractor agrees to hold harmless DSHS and its employees, and all enrollees served under the terms of this agreement in the event of non-payment by the Contractor. The subcontractor further agrees to indemnify and hold harmless DSHS and its employees against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may in any manner accrue against DSHS or its employees through the intentional misconduct, negligence, or omission of the subcontractor, its agents, officers, employees or contractors.

8.4.6. If the subcontract includes physician services, provisions for compliance with the PCP requirements stated in this agreement.

8.4.7. A ninety (90) day termination notice provision.

8.4.8. A specific termination provision for termination with short notice when a provider is excluded from participation in the Medicaid program.

8.4.9. The subcontractor agrees to comply with the appointment wait time standards of this agreement. The subcontract must provide for regular monitoring of timely access and corrective action if the subcontractor fails to comply with the appointment wait time standards (42 CFR 438.206(c)(1).

8.4.10. A provision for ongoing monitoring and periodic formal review that is consistent with industry standards and OIC regulations. Formal review must be completed no less than once every three years and must identify deficiencies or areas for improvement and provide for corrective action (42 CFR 438.230(b)).

8.5. **Health Care Provider Subcontracts Delegating Administrative Functions:** Subcontracts that delegate administrative functions under the terms of this agreement shall include the following additional provisions:

8.5.1. For those subcontractors at financial risk, that the subcontractor shall maintain the Contractor's solvency requirements throughout the term of the agreement.

8.5.2. Clear descriptions of any administrative functions delegated by the Contractor in the subcontract, including but not limited to utilization/ medical management, claims processing, enrollee grievances and appeals, and the provision of data or information necessary to fulfill any of the Contractor's obligations under this agreement.

8.5.3. How frequently and by what means the Contractor will monitor compliance with solvency requirements and requirements related to any administrative function delegated in the subcontract.

8.5.4. Whether referrals for enrollees will be restricted to providers affiliated with the group and, if so, a description of those restrictions.

8.6. **Excluded Providers:**

8.6.1. Pursuant to Section 1128 of the Social Security Act, the Contractor may not subcontract with an individual practitioner or provider, or an entity with an officer, director, agent, or manager, or an individual who owns or has a controlling interest in the entity, who has been: convicted of crimes as specified in Section 1128 of the Social Security Act, excluded from participation in the Medicare and Medicaid program, assessed a civil penalty under the provisions of Section 1128, has a contractual relationship with an entity convicted of a crime specified in Section 1128, or is a person described in Section 7.26 of this agreement, Excluded Persons.

8.6.2. In addition, if DSHS terminates a subcontractor from participation in the Medical Assistance program, the Contractor shall exclude the subcontractor from participation in Healthy Options/SCHIP. The Contractor shall terminate subcontracts of excluded providers immediately when the Contractor becomes aware of such exclusion or when the Contractor receives notice from DSHS, whichever is earlier.

8.7. **Home Health Providers:** If the pending Medicaid home health agency surety bond requirement (Section 4708(d) of the Balanced Budget Act of 1997) becomes effective before or during the term of this agreement, beginning on the effective date of the requirement the Contractor may not subcontract with a home health agency unless the state has obtained a surety bond from the home health agency in the amount required by federal law. The Department will provide a current list of bonded home health agencies upon request to the Contractor.

8.8. **Physician Incentive Plans:** Physician incentive plans, as defined herein, are subject to the conditions set forth in this section in accord with federal regulations (42 CFR 422.208 and 42 CFR 422.210).

8.8.1. **Prohibited Payments:** The Contractor shall make no payment to a physician or physician group, directly or indirectly, under a physician incentive plan as an inducement to reduce or limit medically necessary services provided to an individual enrollee.

8.8.2. **Disclosure Requirements:** Risk sharing arrangements in subcontracts with physicians or physician groups are subject to review and approval by DSHS. The Contractor shall provide the following information about its physician incentive plan, and the physician incentive plans of all its subcontractors in any tier, to the Department annually upon request:

8.8.2.1. Whether the incentive plan includes referral services.

8.8.2.2. If the incentive plan includes referral services:

8.8.2.2.1. The type of incentive plan (e.g. withhold, bonus, capitation)

8.8.2.2.2. For incentive plans involving withholds or bonuses, the percent that is withheld or paid as a bonus.

8.8.2.2.3. Proof that stop-loss protection meets the requirements of 8.8.4.1., including the amount and type of stop-loss protection.

8.8.2.2.4. The panel size and, if commercial members and enrollees are pooled, a description of the groups pooled and the risk terms of each group. Medicaid, Medicare, and commercial members in a physician's or physician group's panel may be pooled provided the terms of risk for the pooled enrollees and commercial members are comparable, and the incentive payments are not calculated separately for pooled enrollees.

Commercial members include military and Basic Health Plan members.

8.8.3. **Substantial Financial Risk:** A physician, or physician group as defined herein, is at substantial financial risk when more than 25% of the total maximum potential payments to the physician or physician group depend on the use of referral services. When the panel size is fewer than 25,000 members arrangements that cause substantial financial risk include, but are not limited to, the following:

8.8.3.1. Withholds greater than 25% of total potential payments

8.8.3.2. Withholds less than 25% of total potential payments but the physician or physician group is potentially liable for more than 25% of total potential payments.

8.8.3.3. Bonuses greater than 33% of total potential payments, less the bonus.

8.8.3.4. Withholds plus bonuses if the withholds plus bonuses equal more than 25% of total potential payments.

8.8.3.5. Capitation arrangements if the difference between the minimum and maximum possible payments is more than 25% of the maximum possible payments, or the minimum and maximum possible payments are not clearly explained in the contract.

8.8.4. **Requirements if a Physician or Physician Group is at Substantial Financial Risk:** If the Contractor, or any subcontractor (e.g. IPA, PHO), places a physician or physician group at substantial financial risk, the Contractor shall assure that all physicians and physician groups have either aggregate or per member stop-loss protection for services not directly provided by the physician or physician group.

8.8.4.1. If aggregate stop-loss protection is provided, it must cover 90% of the costs of referral services that exceed 25% of maximum potential payments under the subcontract.

8.8.4.2. If stop-loss protection is based on a per-member limit, it must cover 90% of the cost of referral services that exceed the limit as indicated below based on panel size, and whether stop-loss is provided separately for professional and institutional services or is combined for the two.

8.8.4.2.1. 1,000 members or fewer, the threshold is $3,000 for professional services and $10,000 for institutional services, or $6,000 for combined services.

8.8.4.2.2. 1,001 - 5,000 members, the threshold is $10,000 for professional services and $40,000 for institutional services, or $30,000 for combined services.

8.8.4.2.3. 5,001 - 8,000 members, the threshold is $15,000 for professional services and $60,000 for institutional services, or $40,000 for combined services.

8.8.4.2.4. 8,001 - 10,000 members, the threshold is $20,000 for professional services and $100,000 for institutional services, or $75,000 for combined services.

8.8.4.2.5. 10,001 - 25,000, the threshold is $25,000 for professional services and $200,000 for institutional services, or $150,000 for combined services.

8.8.4.2.6. 25,001 members or more, there is no risk threshold.

8.8.4.3. For a physician or physician group at substantial financial risk, the Contractor shall periodically conduct surveys of enrollee satisfaction with the physician or physician group. DSHS shall require such surveys annually. DSHS may, at its sole option, conduct enrollee satisfaction surveys that satisfy this requirement and waive the requirement for the Contractor to conduct such surveys. DSHS shall notify the Contractor in writing if the requirement is waived. If DSHS does not waive the requirement, the Contractor shall provide the survey results to DSHS annually upon request. The surveys shall:

8.8.4.3.1. Include current enrollees, and enrollees who have disenrolled within 12 months of the survey for reasons other than loss of Medicaid eligibility or moving outside the Contractor's service area.

8.8.4.3.2. Be conducted according to commonly accepted principles of survey design and statistical analysis.

8.8.4.3.3. Address enrollees satisfaction with the physician or physician group's:

8.8.4.3.3.1. Quality of services provided.

8.8.4.3.3.2. Degree of access to services.

8.8.5. **Sanctions and Penalties:** DSHS or CMS may impose intermediate sanctions, as described in Section 7.7 of this agreement, for failure to comply with the rules in this section.

8.9. **Payment to FQHCs/RHCs:** The Contractor shall not pay a federally qualified health center or a rural health clinic less than the Contractor would pay non-FQHC/RHC providers for the same services (42 USC 1396(m)(2)(A)(ix)).

9. **TERM AND TERMINATION**

9.1. **Term:** This agreement is effective from January 1, 2003 at 12:01 a.m. Pacific Standard Time (PST) through 12:00 a.m. December 31, 2005, PST. This agreement may be extended by mutual agreement of the parties.

9.2. **Termination for Convenience:**

9.2.1. Either party may terminate, upon one-hundred twenty (120) calendar days advance written notice, performance of work under this agreement in whole or in part, whenever, for any reason, either party shall determine that such termination is in its best interest.

9.2.2. In the event DSHS terminates this agreement for convenience, the Contractor shall have the right to assert a claim for the Contractor's direct termination costs. Such claim must be:

9.2.2.1. Delivered to DSHS as provided in Section 7.5., Notices.

9.2.2.2. Asserted within ninety (90) calendar days of termination for convenience, or, in the event the termination was originally issued under the provisions of Section 9.3, Termination by DSHS for Default, ninety (90) calendar days from the date the notice of termination was deemed to have been issued under this section. The Contracts Coordination Unit of MAA (CCU) may extend said ninety (90) calendar days if the Contractor makes a written request to the CCU and CCU deems the grounds for the request to be reasonable. The CCU will evaluate the claim for termination costs and order DSHS to pay the claim or such amount, as s/he deems valid, or deny the claim. The CCU shall notify the Contractor of CCU's decision within sixty (60) calendar days of receipt of the claim.

9.2.3. In the event the Contractor terminates this agreement for convenience, DSHS shall have the right to assert a claim for DSHS' direct termination costs. Such claim must be:

9.2.3.1. Delivered to the Contractor as provided in Section 7.5., Notices.

9.2.3.2. Asserted within ninety (90) calendar days of the date of termination for convenience. The CCU may extend said ninety (90) calendar days if DSHS makes a written request to the CCU and CCU deems the grounds for the request to be reasonable. The CCU will evaluate the claim for termination costs and order the Contractor to pay the claim for such amount, as CCU deems valid, or deny the claim.

9.2.4. In the event the Contractor or DSHS disagrees with the CCU decision entered pursuant to this section, the Contractor or DSHS shall have the right to a dispute resolution as described in Section 7.23, Disputes.

9.2.5. In no event shall the claim for termination costs exceed the average monthly amount paid to the Contractor for the twelve (12) months immediately prior to termination.

9.2.6. In addition to DSHS' or Contractor's direct termination costs, the Contractor or DSHS shall be liable for administrative costs incurred by the other party in procuring supplies or services similar to and/or replacing those terminated.

9.2.7. The Contractor or DSHS shall not be liable for any termination costs if it notifies the other party of its intent not to renew this agreement at least one hundred twenty (120) calendar days prior to the renewal date.

9.2.8. In the event this agreement is terminated for the convenience of either party, the effective date of termination shall be the last day of the month in which the one hundred twenty (120) day notification period is satisfied, or the last day of such later month as may be agreed upon by both parties.

9.3. **Termination by the Contractor for Default:** The Contractor may terminate its performance under this agreement in whole or in part, whenever DSHS shall default in performance of this agreement and shall fail to cure such default within a period of one hundred twenty (120) calendar days (or such longer period as the Contractor may allow) after receipt from the Contractor of a written notice specifying the default. In the event it is determined that DSHS was not in default, DSHS may claim damages for wrongful termination. The procedure for determining damages shall be as stated in Section 9.2.

9.4. **Termination by DSHS for Default:**

9.4.1. DSHS may terminate performance of work under this agreement, in whole or in part, whenever the Contractor shall default in performance of this agreement and shall fail to cure such default within a period of one hundred twenty (120) calendar days (or such longer period as the Contracting Officer may allow) after receipt from the Contracting Officer of a written notice specifying the default. Such termination shall be referred to herein as "Termination for Default."

9.4.2. If after notice of termination of this agreement for default it is determined by DSHS or a court of law that the Contractor was not in default or that the Contractor's failure to perform or make progress in performance was due to causes beyond the control and without the error or negligence of the Contractor, or any subcontractor, the Contractor may claim damages. The procedure for determining damages shall be as stated in Section 9.2.

9.4.3. In the event DSHS terminates this agreement as provided in (a) above, DSHS may procure, upon such terms and in such manner as the Contracting Officer may deem appropriate, supplies or services similar to those terminated, and if the Contractor is judged to be in default by a court of law, DSHS' damages shall be measured by any excess costs for such similar supplies or services. In addition, DSHS' damages may also include reasonable administrative costs incurred in procuring such similar supplies or services.

9.5. **Mandatory Termination:** DSHS will terminate this agreement in the event that the Secretary of DHHS determines that the Contractor does not meet the requirements for participation in the Medicaid program pursuant to Title XIX of the Social Security Act and all amendments.

In addition, DSHS is required under federal law to either impose temporary management or terminate this agreement if the Contractor is repeatedly found to not meet federal requirements for managed care Contractors, as specified in Section 1903(m) of the Social Security Act. Should this circumstance arise, DSHS will terminate this agreement consistent with Section 9.4, Termination by DSHS for Default.

9.6. **Termination for Reduction in Funding:** In the event funding from state, federal, or other sources is withdrawn, reduced or limited in any way after the effective date of this agreement and prior to the termination date, DSHS may terminate the agreement under the "Termination for Convenience" clause.

9.7. **Information on Outstanding Claims at Termination:** In the event this agreement is terminated, the Contractor shall provide DSHS, within three hundred and sixty-five (365) calendar days, all available information reasonably necessary for the reimbursement of any outstanding claims for services to enrollees (42 CFR 434.6(a)(6)). Information and reimbursement of such claims is subject to the provisions of Section 3, Payment.

9.8. **Continued Responsibilities:** After the termination of this agreement, the Contractor remains obligated to:

9.8.1. Cover hospitalized enrollees until discharge consistent with Section 3.7.

9.8.2. Submit reports required under Section 6.

9.8.3. Provide access to records as required in Section 7.15.

9.8.4. Provide the administrative services associated with covered services (e.g. claims processing, enrollee appeals) provided to enrollees under the terms of this agreement.

9.9. **Enrollee Notice of Termination:** DSHS shall inform enrollees when notice is given by either party of its intent to terminate this agreement as provided herein.

9.10. **Pre-termination Dispute Resolution:** If the Contractor disagrees with a DSHS decision to terminate this agreement, other than a termination for convenience, the Contractor will have the right to a dispute resolution as described in Section 7.23, Disputes.

10. SERVICE DELIVERY

10.1. **Scope of Services:** The Contractor shall cover enrollees for preventive care and diagnosis and treatment of illness and injury as set forth in Section 11, Schedule of Benefits. If a specific procedure or element of a covered service is covered by DSHS under its fee-for-service program as described in DSHS' billing instructions, the Contractor shall cover it subject to the specific exclusions and limitations in Section 11, Schedule of Benefits. Except as otherwise specifically provided in this agreement, the Contractor shall provide covered services in the amount, duration and scope described in the Medicaid State Plan.

Except as specifically provided in Section 10.17, this shall not be construed to prevent the Contractor from establishing utilization control measures as it deems necessary to assure that services are appropriately utilized, provided that utilization control measures do not deny medically necessary covered services to enrollees. The Contractor may limit coverage of services to participating providers except as specifically provided in Section 4, Access and Capacity, Section 11, Schedule of Benefits, for emergency services, and as necessary to provide medically necessary services as described in 10.1.2.2., Urgent Services.

10.1.1. **In Service Area:** In the service area, as defined in Section 2.1, the Contractor shall cover enrollees for all medically necessary services included in the scope of services covered by this agreement.

10.1.2. **Out of Service Area:** The Contractor shall cover emergency, post-stabilization and urgent care services, for enrollees temporarily outside of the service area or who have moved to another service area but are still enrolled with the Contractor. Urgent care is associated with the presentation of medical signs that require immediate attention, but are not life threatening. The Contractor may require pre-authorization for urgent care services as long as the wait times specified in Section 4.4, Appointment Standards, are not exceeded.

For the enrollees temporarily outside of the service area or who have moved to another service area but are still enrolled with the Contractor, the Contractor shall cover services that are neither emergent nor urgent but are medically necessary and cannot reasonably wait until enrollee's return to the service area. The Contractor is not required to cover non-symptomatic (i.e. preventive care) out of the service area. The contractor may request pre-authorization for such services as long as the wait times specified in Section 4.4, Appointment Standards, are not exceeded.

10.1.3. **Coverage Limitation:** When an enrollee moves out of a service area, or is temporarily staying with a parent or relative outside the service area, coverage shall be limited to ninety (90) calendar days beginning with the first of the month following the month in which the enrollee changes residence. The Contractor is not responsible for coverage of any services when an enrollee is outside the United States of America and its territories and possessions.

10.2. **Medical Necessity Determination:** The Contractor shall determine which services are medically necessary, according to utilization management requirements included in the Quality Improvement Program Standards, Exhibit A and according to the definition of Medically Necessary Services in this agreement. The Contractor's determination of medical necessity in

specific instances shall be final except as specifically provided in this agreement regarding appeals, fair hearings and independent review.

10.3. **Enrollee Choice of PCP:** The Contractor shall allow, to the extent possible and appropriate, each new enrollee to choose a participating PCP. In the case of newborns, the parent shall choose the newborn's PCP. If the enrollee does not make a choice at the time of enrollment, the Contractor shall assign the enrollee to a PCP or clinic, within reasonable proximity to the enrollee's home, no later than fifteen (15) working days after coverage begins. The Contractor shall allow an enrollee to change PCP or clinic at anytime with the change becoming effective no later than the beginning of the month following the enrollees request for the change (WAC 388-538-060 and WAC 284-43-251 (1)).

The Contractor shall allow children with special health care needs who utilize a specialist frequently to retain the specialist as a PCP, or alternatively, be allowed direct access to specialists for needed care. The Contractor shall also allow enrollees with special health care needs as defined in WAC 388-538-050 to retain a specialist as a PCP or be allowed direct access to a specialist if the assessment required under the provisions of this agreement demonstrates a need for a course of treatment or regular monitoring by such specialist (42 CFR 438.208).

10.4. **Continuity of Care:** The Contract shall ensure the Continuity of Care, as defined herein, for enrollees in an active course of treatment for a chronic or acute medical condition. The Contractor shall ensure that medically necessary care for enrollees is not interrupted.

10.4.1. For changes in the Contractor's provider network or service areas, the Contractor shall comply with the provisions of Sections 2.1.3.3. and 4.11.2.

10.4.2. If possible and reasonable, the Contractor shall preserve enrollee provider relationships through transitions.

10.4.3. Where preservation of provider relationships is not possible and reasonable, the Contractor shall provide transition to a provider who will provide equivalent, uninterrupted care as expeditiously as the enrollee's medical condition requires.

10.4.4. The Contractor shall allow new enrollees with the Contractor to fill prescriptions written prior to enrollment for the lesser of:

10.4.4.1. 30 calendar days after enrollment with the Contractor;

10.4.4.2. Or prescription expiration;

10.4.4.3. Or a participating provider performs an examination of the enrollee to evaluate the need for the prescription.

10.5. **Coordination of Care:** The Contractor shall ensure that health care services are coordinated for enrollees, in accord with the provisions of the Quality Improvement Program Standards, Exhibit A, and as follows:

10.5.1. The Contractor shall ensure that PCPs are responsible for the provision, coordination, and supervision of health care to meet the needs of each enrollee, including initiation and coordination of referrals for medically necessary specialty care. The Contractor shall also provide or shall ensure PCPs provide ongoing coordination of community-based services required by enrollees, including but not limited to: First Steps Maternity Services and Maternity Case Management, Transportation, Regional Support Networks for mental health services, developmental disability services, local health departments, Title V services, home and community services for older and physically disabled individuals, alcohol and substance abuse services, and services for children with special health care needs. The Contractor shall provide support services to assist PCPs in providing such coordination of it is not provided directly by the Contractor (42 CFR 438.208). The Contractor shall also ensure that enrollee health information is shared between providers in a manner that facilitates coordination of care while protecting confidentiality and enrollee rights.

10.5.2. The Contractor shall ensure that PCPs, in consultation with other appropriate health care professionals, assess and develop individualized treatment plans for children with special health care needs and enrollees with special health care needs as defined herein, which ensure integration of clinical and non-clinical disciplines and services in the overall plan of care. Documentation regarding the assessment and treatment plan shall be in the enrollee's case file, including enrollee participation in the development of the treatment plan. If the Contractor requires approval of the treatment plan, approval must be provided in a timely manner appropriate to the enrollee's health condition (42 CFR 438.208(c)).

10.5.3. The Contractor shall identify or shall ensure that practitioners identify enrollees with special health care needs as defined in WAC 388-538-050. The Contractor's obligation for identification of enrollees with special health care needs is limited to identification in the course of any health care visit initiated by the enrollee.

10.6. **Second Opinions:** The Contractor must provide for a second opinion regarding the enrollee's health care from a qualified health care professional within the Contractor's network, or arrange for the enrollee to obtain one outside the Contractor's network, at no cost to the enrollee.

This section shall not be construed to require the Contractor to cover unlimited second opinions, nor to require the Contractor to cover any services other than the professional services of the second opinion provider.

10.7. **Enrollee Self-Determination:** The Contractor shall ensure that all providers: obtain informed consent prior to treatment from enrollees, or persons authorized to consent on behalf of an enrollee as described in RCW 7.70.065; comply with the provisions of the Natural Death Act (RCW 70.122) and state and federal Medicaid rules concerning advance directives (WAC 388-501-0125 & 42 CFR 438.6); and, when appropriate, inform enrollees of their right to make anatomical gifts (RCW 68.50.540).

10.8. **Compliance with Federal Regulations for Sterilizations and Hysterectomies:** The Contractor shall assure that all sterilizations and hysterectomies performed under this agreement are in compliance with 42 CFR 441 Subpart F, and that the DSHS Sterilization Consent Form (DSHS 13-364(x)) or its equivalent is used.

10.9. **Program Information:** At the Contractor's request, DSHS shall provide the Contractor with pertinent documents including statutes, regulations, and current versions of billing instructions and other written documents which describe DSHS policies and guidelines related to service coverage and reimbursement.

10.10. **Confidentiality of Enrollee Information:** The Contractor shall comply with all state and federal laws and regulations concerning the confidentiality of enrollee information.

10.10.1. The use or disclosure of any information concerning an enrollee, including but not limited to medical records, by the Contractor and its subcontractors for any purpose not directly connected with the provision of services under this agreement is prohibited, except by written consent of the enrollee, his/her representative, or his/her responsible parent or guardian, or as otherwise provided by law.

10.10.2. The Contractor shall not require parental or guardian consent for, nor inform parents or guardians of, the following services provided to enrollees under age eighteen (18): reproductive health (State v. Koome, 1975), sexually-transmitted diseases (RCW 70.24.110), drug and alcohol treatment (RCW 70.96A.095), and mental health (RCW

71.34.200), except as specifically provided in law. The Contractor shall suppress these services on any subscriber reports.

10.10.3. The Contractor and DSHS agree to share information regarding enrollees in a manner that complies with applicable state and federal law protecting confidentiality of such information (42 CFR 431 Subpart F, RCW 5.60.060(4), RCW 70.02).

10.10.4. Retained client data shared by DSHS with the Contractor, due to the confidentiality of the information must be maintained throughout the life cycle of the data, to include any record retention cycle, or archival period, in a manner that will retain its confidential nature regardless of the age or media format of the data.

10.11. **Marketing:** The Contractor, and any subcontractors through which the Contractor provides covered services, shall comply with the following requirements regarding marketing:

10.11.1. All marketing materials must be reviewed by and have the prior written approval of DSHS.

10.11.2. Marketing materials shall not contain misrepresentations, or false, inaccurate or misleading information.

10.11.3. Marketing materials must be distributed in all services areas the Contractor serves.

10.11.4. Marketing materials must be in compliance with Section 4.7. Marketing materials in English must give directions in the Medicaid eligible population's primary languages for obtaining understandable materials in accord with contract Section 4.7.2. DSHS may determine, in its sole judgment, if materials that are primarily visual meet the requirements of contract Section 4.7.

10.11.5. The Contractor shall not offer anything of value as an inducement to enrollment.

10.11.6. The Contractor shall not use the sale of other insurance to attempt to influence enrollment.

10.11.7. The Contractor shall not directly or indirectly conduct door-to-door, telephonic or other cold-call marketing of enrollment.

10.12. **Information Requirements for Enrollees and Potential Enrollees:** The Contractor shall provide sufficient, accurate oral and written information to potential enrollees to assist them in making an informed decision about

enrollment (SSA 1932(d)(2) and 42 CFR 438.10). The Contractor shall provide to potential enrollees upon request and to each enrollee, within fifteen (15) working days of enrollment, at any time upon request, and at least once a year, the information needed to understand benefit coverage and obtain care. All enrollee information shall have the prior written approval of DSHS. Changes to State or Federal law shall be reflected in information to enrollees no more than ninety (90) calendar days after the effective date of the change and enrollees shall be notified at least thirty (30) calendar days prior to the effective date if, in the sole judgment of DSHS, the change is significant in regard to the enrollees' quality of or access to care.

The Contractor's written information to enrollees and potential enrollees shall include:

10.12.1. How to choose a PCP, including general information on available PCPs and how to obtain specific information including a list of PCPs that includes their identity, location, languages spoken, qualifications, practice restrictions, and availability.

10.12.2. General information regarding specialists available to enrollees and how to obtain specific information including a list of specialists that includes their identity, location, languages spoken, qualifications, practice restrictions, and availability.

10.12.3. How to obtain information regarding any limitations to the availability of or referral to specialists to assist the enrollee in selecting a PCP.

10.12.4. How to obtain information regarding Physician Incentive Plans (42 CFR 422.210(b)), and information on the Contractor's structure and operations.

10.12.5. How to change a PCP.

10.12.6. Informed consent guidelines.

10.12.7. Information regarding conversion rights under RCW 48.46.450 or RCW 48.44.370.

10.12.8. How to request a disenrollment.

10.12.9. The following Information regarding advance directives:

10.12.9.1. A statement about an enrollee's right to make decisions concerning an enrollee's medical care, accept or refuse surgical

or medical treatment, execute an advance directive, and revoke an advance directive at any time.

10.12.9.2. The written policies and procedures of the Contractor concerning advance directives, including any policy that would preclude the Contractor or subcontractor from honoring an enrollee's advance directive.

10.12.9.3. An enrollee's rights under state law.

10.12.10. How to recommend changes in the Contractor's policies and procedures.

10.12.11. Health promotion, health education and preventive health services available.

10.12.12. How to obtain assistance from the Contractor in using the grievance, appeal and independent review processes (must assure enrollees that information will be kept confidential except as needed to process the grievance, appeal or independent review).

10.12.13. The right to initiate a grievance or file an appeal, in accord with the Contractor's DSHS approved policies and procedures regarding grievances and appeals.

10.12.14. The right to request a DSHS Fair Hearing after the Contractor's appeal process is exhausted, how to request a DSHS Fair Hearing, and the rules that govern representation at the Fair Hearing.

10.12.15. The right to request an independent review in accord with RCW 48.43.535 and WAC 246-305 after the DSHS Fair Hearing process is exhausted and how to request an independent review.

10.12.16. The right to appeal an independent review decision to the DSHS Board of Appeals and how to request such an appeal.

10.12.17. Requirements and timelines for grievances, appeals, fair hearings, independent review and DSHS Board of Appeals.

10.12.18. Rights and responsibilities, including potential payment liability, regarding the continuation of services that are the subject of appeal or fair hearing.

10.12.19. Availability of toll-free numbers for information on grievance, and appeals.

10.12.20. The enrollee's rights and responsibilities with respect to receiving covered services.

10.12.21. Information about covered benefits and how to contact DSHS regarding services that may be covered by DSHS, but are not covered benefits under this agreement.

10.12.22. Information regarding the availability of and how to access or obtain interpretation services and translation of written information.

10.12.23. How to obtain information in alternative formats.

10.12.24. The enrollees right to and procedure for obtaining a second opinion.

10.13. **Prohibition on Enrollee Charges for Covered Services:** Under no circumstances shall the Contractor, or any providers used to deliver services covered under the terms of this agreement, charge enrollees for covered services in excess of the copayments DSHS implements in its fee-for-service program as referenced in Section 3.11 (SSA 1932(b)(6), SSA 1128B(d)(1)).

10.14. **Provider/Enrollee Communication:** The Contractor may not prohibit, or otherwise restrict, a health care professional acting within their lawful scope of practice, from advising or advocating on behalf of an enrollee who is his or her patient, for the following (42 CFR 438.102(a)(1)):

10.14.1. The enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.

10.14.2. Any information the enrollee needs in order to decide among all relevant treatment options.

10.14.3. The risks, benefits, and consequences of treatment or non-treatment.

10.14.4. The enrollee's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

10.15. **Provider Nondiscrimination:**

10.15.1. The Contractor shall not discriminate, with respect to participation, reimbursement, or indemnification, against providers practicing within their licensed scope of practice solely on the basis of the type of license or certification they hold.

10.15.2. If the Contractor declines to include individual or groups of providers in its network, it shall give the affected providers written notice of the reason for its decision.

10.15.3. The Contractor's provider selection policies and procedures shall not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment (42CFR 438.214(c)).

10.15.4. Consistent with the Contractors responsibilities to the enrollees, this section may not be construed to require the Contractor to contract with providers beyond the number necessary to meet the needs of its enrollees; preclude the Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or preclude the Contractor from establishing measures that are designed to maintain quality of services and control costs.

10.16. **Experimental and Investigational Services:**

10.16.1. If the Contractor excludes or limits benefits for any services for one or more medical conditions or illnesses because such services are deemed to be experimental or investigational, the Contractor shall develop and follow policies and procedures for such exclusions and limitations. The policies and procedures shall identify the persons responsible for such decisions. The policies and procedures and any criteria for making decisions shall be made available to DSHS upon request.

In making the determination, whether a service is experimental and investigational and, therefore, not a covered service, the Contractor shall consider the following:

10.16.1.1. Evidence in peer-reviewed, medical literature, as defined herein, and pre-clinical and clinical data reported to the National Institute of Health and/or the National Cancer Institute, concerning the probability of the service maintaining or significantly improving the enrollee's length or quality of life, or ability to function, and whether the benefits of the service or treatment are outweighed by the risks of death or serious complications.

10.16.1.2. Whether evidence indicates the service or treatment is likely to be as beneficial as existing conventional treatment alternatives.

10.16.1.3. Any relevant, specific aspects of the condition.

10.16.1.4. Whether the service or treatment is generally used for the condition in the state of Washington.

10.16.1.5. Whether the service or treatment is under continuing scientific testing and research.

10.16.1.6. Whether the service or treatment shows a demonstrable benefit for the condition.

10.16.1.7. Whether the service or treatment is safe and efficacious.

10.16.1.8. Whether the service or treatment will result in greater benefits for the condition than another generally available service.

10.16.1.9. If approval is required by a regulating agency, such as the Food and Drug Administration, whether such approval has been given before the date of service.

10.16.2. Criteria to determine whether a service is experimental or investigational shall be no more stringent for Healthy Options enrollees than that applied to any other enrollees. A service or treatment that is not experimental for one enrollee with a particular medical condition cannot be determined to be experimental for another enrollee with the same medical condition and similar health status.

10.16.3. A service or treatment may not be determined to be experimental and investigational solely because it is under clinical investigation when there is sufficient evidence in peer-reviewed medical literature to draw conclusions, and the evidence indicates the service or treatment will probably be of significant benefit to enrollees.

10.16.4. A determination made by the Contractor shall be subject to appeal through the Contractor's appeal process, including independent review, through the DSHS fair hearing process and independent review under WAC 246-305.

10.17. **Enrollee Rights and Protections:**

10.17.1. The Contractor shall have written policies regarding enrollee rights (42 CFR 438.100(a)(1)).

10.17.2. The Contractor shall comply with any applicable Federal and State laws that pertain to enrollee rights and ensure that its staff and affiliated providers take those rights into account when furnishing services to enrollees (42 CFR 438.100(a)(2)).

10.17.3. The Contractor shall guarantee each enrollee the following rights (42 CFR 438.100(b)(2)):

10.17.3.1. To be treated with respect and with consideration for their dignity and privacy.

10.17.3.2. To receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's ability to understand.

10.17.3.3. To participate in decisions regarding their health care, including the right to refuse treatment.

10.17.3.4. To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.

10.17.3.5. To request and receive a copy of their medical records, and to request that they be amended or corrected, as specified in 45 CFR 164.

10.17.3.6. Each enrollee must be free to exercise their rights, and exercise of those rights must not adversely affect the way the Contractor or its subcontractors treat the enrollee (42 CFR 438.100(c)).

10.18. **Authorization of Services:** In regard to the authorization of services for enrollees, the Contractor shall have in place policies and procedures, and shall require that subcontractors with delegated authority for authorization to comply with such policies and procedures, that comply with 42 CFR 438.210, WAC 388-538 and the provisions of this agreement.

10.18.1. The Contractor shall have in effect mechanisms to ensure consistent application of review criteria for authorization decisions.

10.18.2. The Contractor shall consult with the requesting provider when appropriate.

10.18.3. The Contractor shall require that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease.

10.18.4. The Contractor shall notify the requesting provider, and give the enrollee written notice of any decision by the Contractor to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice shall meet

the following requirements, except that the notice to the provider need not be in writing (42 CFR 438.404):

10.18.4.1. The notice to the enrollee shall be in writing and shall meet the requirements of Section 4.7 of this agreement to ensure ease of understanding.

10.18.4.2. The notice shall explain the following:

10.18.4.2.1. The action the Contractor has taken or intends to take.

10.18.4.2.2. The reasons for the action.

10.18.4.2.3. The enrollee's right to file an appeal.

10.18.4.2.4. The procedures for exercising the enrollee's rights.

10.18.4.2.5. The circumstances under which expedited resolution is available and how to request it.

10.18.4.2.6. The enrollee's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the enrollee may be required to pay for these services.

10.18.5. The Contractor shall provide for the following timeframes for authorization decisions and notices:

10.18.5.1. For denial of payment that may result in payment liability for the enrollee, at the time of any action affecting the claim.

10.18.5.2. For termination, suspension, or reduction of previously authorized services, ten (10) calendar days prior to such termination, suspension, or reduction, except if the criteria stated in 42 CFR 431.213 and 431.214 are met. The notice shall be mailed within this ten (10) calendar day period by a method that certifies receipt and assures delivery within three (3) calendar days.

10.18.5.3. For standard authorization decisions, provide notice as expeditiously as the enrollee's health condition requires and within timeframes that may not exceed 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days under the following circumstances:

10.18.5.3.1. The enrollee, or the provider, requests extension; or

10.18.5.3.2. The Contractor justifies and documents a need for additional information and how the extension is in the enrollee's interest.

10.18.5.3.3. If the Contractor extends that timeframe, it shall:

10.18.5.3.3.1. Give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision; and

10.18.5.3.3.2. Issue and carry out its determination as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

10.18.5.4. For cases in which a provider indicates, or the Contractor determines, that following the timeframe for standard authorization decisions could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, the Contractor shall make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than three (3) working days after receipt of the request for service. The Contractor may extend the three (3) working days by up to 14 calendar days under the following circumstances:

10.18.5.4.1. The enrollee, or the provider, requests extension; or

10.18.5.4.2. The Contractor justifies and documents a need for additional information and how the extension is in the enrollee's interest.

10.18.6. If the Contractor fails to comply with the timeframes in this section, the Contractor shall cover the services that are the subject of the authorization.

10.19. **Grievance System:** The Contractor shall have a grievance system which complies with the requirements of 42 CFR 438 Subpart F, WAC 388-538 and, insofar as it is not in conflict with 42 CFR 438 Subpart F or WAC 388-538, or WAC 284-43 Subpart F. The grievance system shall include a grievance process, an appeal process and access to the DSHS fair hearing process.

10.19.1. The Contractor shall submit policies and procedures addressing the grievance system, which comply with the requirements of this

agreement to the DSHS, MAA, Division of Program Support, Contract Manager assigned to the Contractor by September 2, 2003 and upon change thereafter. The Contractor shall include copies of all related notices to enrollees. DSHS must approve, in writing, all policies and procedures regarding the grievance system. Implementation of the grievance system requirements in this agreement shall be in place by October 1, 2003.

10.19.2. The Contractor shall give enrollees any assistance necessary in completing forms and other procedural steps for grievances and appeals.

10.19.3. The Contractor shall acknowledge receipt of each grievance, either orally or in writing, and appeal, in writing, within five (5) working days.

10.19.4. The Contractor shall ensure that decision makers on grievances and appeals were not involved in previous levels of review or decision-making.

10.19.5. Decisions regarding grievances and appeals shall be made by health care professionals with clinical expertise in treating the enrollee's condition or disease if any of the following apply:

10.19.5.1. If the enrollee is appealing an action concerning medical necessity.

10.19.5.2. If an enrollee grievance concerns a denial of expedited resolution of an appeal.

10.19.5.3. If the grievance or appeal involves any clinical issues.

10.19.6. **Grievance Process**: The following requirements are specific to the grievance process:

10.19.6.1. Only an enrollee may file a grievance with the Contractor; a provider may not file a grievance on behalf of an enrollee.

10.19.6.2. Enrollees may file a grievance orally or in writing.

10.19.6.3. The Contractor shall complete the disposition of a grievance and notice to the affected parties within ninety (90) calendar days of receiving the grievance.

10.19.6.4. The Contractor may notify enrollees of the disposition of grievances orally or in writing for grievances not involving clinical issues. Notices of disposition for clinical issues must be in writing.

10.19.6.5. Enrollees do not have the right to a fair hearing in regard to the disposition of a grievance.

10.19.7. **Appeal Process**: The following requirements are specific to the appeal process:

10.19.7.1. If the Contractor fails to meet the timeframes in this section concerning any appeal, including timely notice of actions, the Contractor shall cover the services that are the subject of the appeal.

10.19.7.2. An enrollee, or a provider acting on behalf of the enrollee and with the enrollee's written consent, may appeal a Contractor action.

10.19.7.3. For appeals of standard service authorization decisions, an enrollee must file an appeal, either orally or in writing, within ninety (90) calendar days of the date on the Contractor's notice of action. This also applies to an enrollee's request for an expedited appeal.

10.19.7.4. For appeals for termination, suspension, or reduction of previously authorized services when the enrollee requests continuation of such services, an enrollee must file an appeal within ten (10) calendar days of the date of the Contractor's mailing of the notice of action. If the enrollee is notified in a timely manner and the enrollee's request for continuation of services is not timely, the Contractor is not obligated to continue services and the timeframes for appeals of standard service authorization apply.

10.19.7.5. Oral inquiries seeking to appeal an action shall be treated as appeals and be confirmed in writing, unless the enrollee or provider requests an expedited resolution.

10.19.7.6. The appeal process shall provide the enrollee a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. The Contractor shall inform the enrollee of the limited time available for this in the case of expedited resolution.

10.19.7.7. The appeal process shall provide the enrollee and the enrollee's representative opportunity, before and during the appeals process, to examine the enrollee's case file, including medical records, and any other documents and records considered during the appeal process.

10.19.7.8. The appeal process shall include as parties to the appeal, the enrollee and the enrollee's representative, or the legal representative of the deceased enrollee's estate.

10.19.7.9. The Contractor shall resolve each appeal and provide notice, as expeditiously as the enrollee's health condition requires, within the following timeframes:

10.19.7.9.1. For standard resolution of appeals and for appeals for termination, suspension, or reduction of previously authorized services and notice to the affected parties, no longer than forty-five (45) calendar days from the day the Contractor receives the appeal. This timeframe may not be extended.

10.19.7.9.2. For expedited resolution of appeals, including notice to the affected parties, no longer than three (3) calendar days after the Contractor receives the appeal. This timeframe may not be extended.

10.19.7.10. The notice of the resolution of the appeal shall:

10.19.7.10.1. Be in writing. For notice of an expedited resolution, the Contractor shall also make reasonable efforts to provide oral notice.

10.19.7.10.2. Include the results of the resolution process and the date it was completed.

10.19.7.10.3. For appeals not resolved wholly in favor of the enrollee:

10.19.7.10.3.1. Include information on the enrollee's right to request a DSHS fair hearing and how to do so.

10.19.7.10.3.2. Include information on the enrollee's right to receive services while the hearing is pending and how to make the request.

10.19.7.10.3.3. Inform the enrollee that the enrollee may be held liable for the amount the Contractor pays for services received while the hearing is pending, if the hearing decision upholds the Contractor's action.

10.19.7.11. **Expedited Appeal Process**:

10.19.7.11.1. The Contractor shall establish and maintain an expedited appeal review process for appeals when the Contractor determines, for a request from the enrollee, or the provider indicates, in making the request on the enrollee's behalf or supporting the enrollee's request, that taking the time for a standard resolution could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function.

10.19.7.11.2. The Contractor shall make a decision on the enrollee's request for expedited appeal and provide notice, as expeditiously as the enrollee's health condition requires, within three (3) calendar days after the Contractor receives the appeal. The Contractor shall also make reasonable efforts to provide oral notice.

10.19.7.11.3. The Contractor shall ensure that punitive action is neither taken against a provider who requests an expedited resolution or supports an enrollee's appeal.

10.19.7.11.4. If the Contractor denies a request for expedited resolution of an appeal, it shall transfer the appeal to the timeframe for standard resolution and make reasonable efforts to give the enrollee prompt oral notice of the denial, and follow up within two (2) calendar days with a written notice.

10.19.8. **Fair Hearing:**

10.19.8.1. A provider may not request a state fair hearing on behalf of an enrollee.

10.19.8.2. If an enrollee does not agree with the Contractor's resolution of the appeal, the enrollee may file a request for a DSHS fair hearing within the following time frames (see WAC 388-538-112 for the fair hearing process for enrollees):

10.19.8.2.1. For appeals regarding a standard service, within ninety (90) calendar days of the date on the Contractor's mailing of the notice of the resolution of the appeal.

10.19.8.2.2. For appeals regarding termination, suspension, or reduction of a previously authorized service, if the enrollee requests continuation of services, within ten (10) calendar days of the date on the Contractor's mailing of the notice of the resolution of the appeal. If the enrollee is notified in a timely manner and the enrollee's request for continuation of

services is not timely, the Contractor is not obligated to continue services and the timeframes for appeals of standard service authorization apply.

10.19.8.3. If the enrollee requests a fair hearing, the Contractor shall provide to DSHS upon request and within three (3) working days, all Contractor-held documentation related to the appeal, including but not limited to, any transcript(s), records, or written decision(s) from participating providers or delegated entities.

10.19.8.4. The Contractor will have the opportunity to present its position at the fair hearing.

10.19.8.5. The Contractor's medical director or designee shall review all cases where a fair hearing is requested and any related appeals, when medical necessity is an issue.

10.19.8.6. The enrollee must exhaust all levels of resolution and appeal within the Contractor's grievance system prior to filing a request for a fair hearing with DSHS.

10.19.8.7. DSHS will notify the Contractor of fair hearing determinations. The Contractor will be bound by the fair hearing determination, whether or not the fair hearing determination upholds the Contractor's decision. Implementation of such fair hearing decision shall not be the basis for disenrollment of the enrollee by the Contractor.

10.19.8.8. If the fair hearing decision is not within the purview of this agreement, then DSHS will be responsible for the implementation of the fair hearing decision.

10.19.9. **Independent Review**: After exhausting both the Contractor's appeal process and the fair hearing process an enrollee has a right to independent review in accord with RCW 48.43.535 and WAC 284-483-630.

10.19.10. An enrollee who is aggrieved by the final decision of an independent review may appeal the decision to the DSHS Board of Appeals in accord with WAC 388-02-560 through 388-02-590. Notice of this right will be included in the written determination from the Contractor or Independent Review Organization.

10.19.11. **Continuation of Services**:

10.19.11.1. The Contractor shall continue the enrollee's services if all of the following apply:

10.19.11.1.1. The enrollee or the provider files for an appeal, fair hearing or independent review on or before the later of the following:

10.19.11.1.1.1. Within ten (10) calendar days of the Contractor mailing the notice of action, which for actions involving services previously authorized, shall be delivered by a method that certifies receipt and assures delivery within three (3) calendar days.

10.19.11.1.1.2. The intended effective date of the Contractor's proposed action.

10.19.11.1.2. The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment.

10.19.11.1.3. The services were ordered by an authorized provider.

10.19.11.1.4. The original period covered by the original authorization has not expired.

10.19.11.1.5. The enrollee requests an extension of services.

10.19.11.2. If, at the enrollee's request, the Contractor continues or reinstates the enrollee's services while the appeal, fair hearing, independent review or DSHS Board of Appeals is pending, the services shall be continued until one of the following occurs:

10.19.11.2.1. The enrollee withdraws the appeal, fair hearing or independent review request.

10.19.11.2.2. Ten (10) calendar days pass after the Contractor mails the notice of the resolution of the appeal and the enrollee has not requested a state fair hearing (with continuation of services until the state fair hearing decision is reached) within the ten (10) calendar days.

10.19.11.2.3. Ten (10) calendar days pass after DSHS mails the notice of resolution of the state fair hearing and the enrollee has not requested an independent review (with continuation of services until the independent review decision is reached) within the ten (10) calendar days.

10.19.11.2.4. Ten (10) calendar days pass after the Contractor mails the notice of the resolution of the independent review and the enrollees has not requested a DSHS Board of Appeals (with continuation of services until the DSHS Board of Appeals decision is reached) within ten calendar days.

10.19.11.2.5. The time period or service limits of a previously authorized service has been met.

10.19.11.3. If the final resolution of the appeal upholds the Contractor's action, the Contractor may recover the amount paid for the services provided to the enrollee while the appeal was pending, to the extent that they were provided solely because of the requirement for continuation of services.

10.19.12. **Effect of Reversed Resolutions of Appeals and Fair Hearings**:

10.19.12.1. If the Contractor, DSHS Office of Administrative Hearings (OAH), independent review organization (IRO) or DSHS Board of Appeals reverses a decision to deny, limit, or delay services that were not provided while the appeal was pending, the Contractor shall authorize or provide the disputed services promptly, and as expeditiously as the enrollee's health condition requires.

10.19.12.2. If the Contractor, OAH, IRO or DSHS Board of Appeals reverses a decision to deny authorization of services, and the enrollee received the disputed services while the appeal was pending, the Contractor shall pay for those services.

10.20. **EPSDT**: The Contractor shall meet all requirements under the DSHS EPSDT program policy and billing instructions. These are available at http://fortress.wa.gov/dshs/maa/Download/Billinginstructions.html and in alternative formats when requested.

11. SCHEDULE OF BENEFITS

11.1. Covered Services:

11.1.1. The Contractor shall cover the services described in this section when medically necessary. The amount and duration of covered services that are medically necessary depends on the enrollee's condition. The Contractor shall not arbitrarily deny or reduce the amount, duration or scope of required services solely because of the enrollee's diagnosis, type of illness or condition.

11.1.2. Except as specifically provided herein, the scope of covered services shall be comparable to the DSHS Medicaid fee-for-service program. For specific covered services, this shall not be construed as requiring the Contractor to cover the specific items covered by DSHS under its fee-for-service program, but shall rather be construed to require the Contractor to cover the same scope of services.

11.1.3. Enrollees have the right to self-refer for certain services to providers paid through separate arrangements with the state of Washington. The Contractor is not responsible for the coverage of the services provided through such separate arrangements. The enrollees also may choose to receive such services from the Contractor. The Contractor shall assure that enrollees are informed, whenever appropriate, of all options in such a way as not to prejudice or direct the enrollee's choice of where to receive the services. If the Contractor in any manner deprives enrollees of their free choice to receive services through the Contractor, the Contractor shall pay the local health department, family planning facility, or RSN for such services up to the limits described herein. The services to which an enrollee may self-refer are:

11.1.3.1. Outpatient mental health services to community mental health providers of the Regional Support Network for Prepaid Health Plan.

11.1.3.2. Family planning services and sexually transmitted disease screening and treatment services provided at family planning facilities, such as Planned Parenthood.

11.1.3.3. Immunizations, sexually-transmitted disease screening and follow-up, immunodeficiency virus (HIV) screening, tuberculosis screening and follow-up, and family planning services through the local health department.

11.1.3.4. Medical services provided to enrollees who have a diagnosis of alcohol and/or chemical dependency or mental health diagnosis are covered when those services are otherwise covered services.

11.1.4. **Inpatient Services**: Provided by acute care hospitals (licensed under RCW 70.41), or nursing facilities (licensed under RCW 18-51) when nursing facility services are not covered by the Department's Aging and Disability Services Administration and the Contractor determines that nursing facility care is more appropriate than acute hospital care. Inpatient physical rehabilitation services are included.

11.1.5. **Outpatient Hospital Services**: Provided by acute care hospitals (licensed under RCW 70.41).

11.1.6. **Emergency Services and Post-stabilization Services**:

11.1.6.1. **Emergency Services:** Emergency services are defined herein.

11.1.6.1.1. The Contractor will provide all inpatient and outpatient emergency services in accord with the requirements of 42 CFR 438.114.

11.1.6.1.2. The Contractor shall cover all emergency services provided by a provider who is qualified to furnish Medicaid services, without regard to whether the provider is a participating or non-participating provider.

11.1.6.1.3. Emergency services shall be provided without requiring prior authorization.

11.1.6.1.4. What constitutes an emergency medical condition may not be limited on the basis of lists of diagnoses or symptoms (42 CFR 438.114 (d)(i)).

11.1.6.1.5.The Contractor shall cover treatment obtained under the following circumstances:

11.1.6.1.5.1. An enrollee had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of an emergency medical condition.

11.1.6.1.5.2. A plan provider or other Contractor representative instructs the enrollee to seek emergency services.

11.1.6.1.6. If there is a disagreement between a hospital and the Contractor concerning whether the patient is stable enough for discharge or transfer, or whether the medical benefits of an unstabilized transfer outweigh the risks, the judgment of the attending physician(s) actually caring for the enrollee at the treating facility prevails and is binding on the Contractor.

11.1.6.2. **Post-stabilization Services:** Post-stabilization services are defined herein.

11.1.6.2.1. The Contractor will provide all inpatient and outpatient post-stabilization services in accord with the requirements of 42 CFR 438.114 and 42 CFR 422.113(c).

11.1.6.2.2. The Contractor shall cover all post-stabilization services provided by a provider who is qualified to furnish Medicaid services, without regard to whether the provider is a participating or non-participating provider.

11.1.6.2.3. The Contractor shall cover post-stabilization services under the following circumstances:

11.1.6.2.3.1. The services are pre-approved by a plan provider or other Contractor representative.

11.1.6.2.3.2. The services are not pre-approved by a plan provider or other Contractor representative, but are administered to maintain the enrollee's stabilized condition within 1 hour of a request to the Contractor for pre-approval of further post-stabilization care services.

11.1.6.2.3.3. The services are not pre-approved by a plan provider or other Contractor representative, but are administered to maintain, improve, or resolve the enrollee's stabilized condition and:

11.1.6.2.3.3.1. The Contractor does not respond to a request for pre-approval within thirty (30) minutes (RCW 48.43.093(d));

11.1.6.2.3.3.2. The Contractor cannot be contacted; or

11.1.6.2.3.3.3. The Contractor representative and the treating physician cannot reach an agreement concerning the enrollee's care and a Contractor physician is not available for consultation. In this situation, the Contractor shall give the treating physician the opportunity to consult with a Contractor physician and the treating physician may continue with care of the enrollee until a Contractor physician is reached or one of the criteria in Section 11.1.6.2.4. is met.

11.1.6.2.4. The Contractor's responsibility for post-stabilization services it has not pre-approved ends when:

11.1.6.2.4.1. A participating provider with privileges at the treating hospital assumes responsibility for the enrollee's care;

11.1.6.2.4.2. A participating provider assumes responsibility for the enrollee's care through transfer;

11.1.6.2.4.3. A Contractor representative and the treating physician reach an agreement concerning the enrollee's care; or

11.1.6.2.4.4. The enrollee is discharged.

11.1.7. **Ambulatory Surgery Center**: Services provided at ambulatory surgery centers.

11.1.8. **Provider Services**: Services provided in an inpatient or outpatient (e.g., office, clinic, emergency room or home) setting by licensed professionals including, but not limited to, physicians, physician assistants, advanced registered nurse practitioners, midwives, podiatrists, audiologists, registered nurses, and certified dietitians.

Provider Services include, but are not limited to:

11.1.8.1. Medical examinations, including wellness exams for adults and EPSDT for children

11.1.8.2. Immunizations

11.1.8.3. Maternity care

11.1.8.4. Family planning services provided or referred by a participating provider or practitioner

11.1.8.5. Performing and/or reading diagnostic tests

11.1.8.6. Private duty nursing

11.1.8.7. Surgical services

11.1.8.8. Surgery to correct defects from birth, illness, or trauma, or for mastectomy reconstruction

11.1.8.9. Anesthesia

11.1.8.10. Administering pharmaceutical products

11.1.8.11. Fitting prosthetic and orthotic devices

11.1.8.12. Rehabilitation services

11.1.8.13. Enrollee health education

11.1.8.14. Nutritional counseling for specific conditions such as diabetes, high blood pressure, and anemia

11.1.8.15. Nutritional counseling when referred as a result of an EPSDT exam

11.1.9. **Tissue and Organ Transplants:** Heart, kidney, liver, bone marrow, lung, heart-lung, pancreas, kidney-pancreas, cornea, and peripheral blood stem cell.

11.1.10. **Laboratory, Radiology, and Other Medical Imaging Services:** Screening and diagnostic services and radiation therapy.

11.1.11. **Vision Care:** Eye examinations for visual acuity and refraction once every twenty-four (24) months for adults and once every twelve (12) months for children under age twenty-one (21). These limitations do not apply to additional services needed for medical conditions. The Contractor may restrict non-emergent care to participating providers. Enrollees may self-refer to participating providers for these services.

11.1.12. **Outpatient Mental Health:**

11.1.12.1. Psychiatric and psychological testing, evaluation and diagnosis:

11.1.12.1.1. Once every twelve (12) months for adults twenty-one (21) and over

11.1.12.1.2. Unlimited for children under age twenty-one (21) when identified in an EPSDT visit

11.1.12.2. Unlimited medication management:

11.1.12.2.1. Provided by the PCP or by PCP referral

11.1.12.2.2. Provided in conjunction with mental health treatment covered by the Contractor

11.1.12.3. Twelve hours per calendar year for treatment

11.1.12.4. Transition to the RSN, as needed to assure continuity of care, when the enrollee has exhausted the benefit covered by the Contractor or when enrollee request such transition

11.1.12.5. Referrals To and From the RSN:

11.1.12.5.1. The Contractor shall cover mental health services provided by the RSN, up to the limits described herein, if the Contractor refers an enrollee to the RSN for those services.

11.1.12.5.2. The Contractor may, but is not required to, accept referrals from the RSN for the mental health services described herein.

11.1.12.6. The Contractor may subcontract with RSNs to provide the outpatient mental health services that are the responsibility of the Contractor. Such agreements shall not be written or construed in a manner that provides less than the services otherwise described in this section as the Contractor's responsibility for outpatient mental health services.

11.1.12.7. The DSHS Mental Health Division (MHD) and Medical Assistance Administration (MAA) shall each appoint a Mental Health Care Coordinator (MHCC). The MHCCs shall be empowered to decide all Contractor and RSN issues regarding outpatient mental health coverage that cannot be otherwise resolved between the Contractor and the RSN. The MHCCs will also undertake training and technical assistance activities that further coordination of care between MAA, MHD, Healthy Options contractors and RSNs. The Contractor shall cooperate with the activities of the MHCCs.

11.1.13. **Occupational Therapy, Speech Therapy, and Physical Therapy:** Services for the restoration or maintenance of a function affected by an enrollee's illness, disability, condition or injury, or for the amelioration of the effects of a developmental disability.

11.1.14. **Pharmaceutical Products:** Prescription drug products according to a Department approved formulary, which includes both legend and over-the-counter (OTC) products. The Contractor's formulary shall include all therapeutic classes in DSHS' fee-for-service drug file and a sufficient variety of drugs in each therapeutic class to meet medically necessary health needs. The Contractor shall provide participating pharmacies and participating providers with its formulary and information about how to request non-formulary drugs. The Contractor shall approve or deny all requests for non-formulary drugs by the business day following the day of request.

Covered drug products shall include:

11.1.14.1. Oral, enteral and parenteral nutritional supplements and supplies, including prescribed infant formulas

11.1.14.2. All Food and Drug Administration (FDA) approved contraceptive drugs, devices, and supplies; including but not limited to Depo-Provera, Norplant, and OTC products

11.1.14.3. Antigens and allergens

11.1.14.4. Therapeutic vitamins and iron prescribed for prenatal and postnatal care.

11.1.15. **Home Health Services:** Home health services through state-licensed agencies.

11.1.16. **Durable Medical Equipment (DME) and Supplies:** Including, but not limited to: DME; surgical appliances; orthopedic appliances and braces; prosthetic and orthotic devices; breast pumps; incontinence supplies for enrollees over three (3) years of age; and medical supplies. Incontinence supplies shall not include non-disposable diapers unless the enrollee agrees.

11.1.17. **Oxygen and Respiratory Services:** Oxygen, and respiratory therapy equipment and supplies.

11.1.18. **Hospice Services:** When the enrollee elects hospice care.

11.1.19. **Blood, Blood Components and Human Blood Products:** Administration of whole blood and blood components as well as human blood products. In areas where there is a charge for blood and/or blood products the Contractor shall cover the cost of the blood or blood products.

11.1.20. **Treatment for Renal Failure:** Hemodialysis, or other appropriate procedures to treat renal failure, including equipment needed in the course of treatment.

11.1.21. **Ambulance Transportation:** The Contractor shall cover ground and air ambulance transportation for emergency medical conditions, as defined herein, including, but not limited to, Basic and Advanced Life Support Services, and other required transportation costs, such as tolls and fares. In addition, the Contractor shall cover ambulance services under two circumstances for non-emergencies:

11.1.21.1. When it is necessary to transport an enrollee between facilities to receive a covered services; and,

11.1.21.2. When it is necessary to transport an enrollee, who must be carried on a stretcher, or who may require medical attention en route (RCW 18.73.180) to receive a covered service.

11.1.22. **Chiropractic Services:** For children when they are referred during an EPSDT exam.

11.1.23. **Neurodevelopmental Services:** When provided by a facility that is not a DSHS recognized neurodevelopmental center.

11.1.24. **Smoking Cessation Services:** For pregnant women through sixty (60) calendar days post pregnancy.

11.2. **Exclusions:**

The following services and supplies are excluded from coverage under this agreement. This shall not be construed to prevent the Contractor from covering any of these services when the Contractor determines it is medically necessary. Unless otherwise required by this agreement, ancillary services resulting from excluded services are also excluded.

11.2.1. **Services Covered By DSHS Fee-For-Service Or Through Selective Contracts:**

11.2.1.1. School Medical Services for Special Students as described in the DSHS billing instructions for School Medical Services.

11.2.1.2. Eyeglass Frames, Lenses, and Fabrication Services covered under DSHS' selective contract for these services, and associated fitting and dispensing services.

11.2.1.3. Voluntary Termination of Pregnancy, including complications.

11.2.1.4. Transportation Services other than Ambulance: Taxi, cabulance, voluntary transportation, and public transportation.

11.2.1.5. Dental Care, Prostheses and Oral Surgery, including physical exams required prior to hospital admissions for oral surgery.

11.2.1.6. Hearing Aid Devices, including fitting, follow-up care and repair.

11.2.1.7. First Steps Maternity Case Management and Maternity Support Services.

11.2.1.8. Sterilizations for enrollees under age 21, or those that do not meet other federal requirements.

11.2.1.9. Health care services provided by a neurodevelopmental center recognized by DSHS.

11.2.1.10. Certain services provided by a health department or family planning clinic when a client self-refers for care.

11.2.1.11. Inpatient psychiatric professional services.

11.2.1.12. Pharmaceutical products prescribed by any provider related to services provided under a separate agreement with DSHS or related to services not covered by the Contractor.

11.2.1.13. Laboratory services required for medication management of drugs prescribed by community mental health providers whose services are purchased by the Mental Health Division.

11.2.1.14. Protease Inhibitors

11.2.1.15. Services ordered as a result of an EPSDT exam that are not otherwise covered services.

11.2.1.16. Gastroplasty, when approved by DSHS in accord with WAC 388-531. The Contractor has no obligation to cover gastroplasty.

11.2.1.17. Prenatal Diagnosis Genetic Counseling provided to enrollees to allow enrollees and their PCPs to make informed decisions regarding current genetic practices and testing. Genetic services beyond Prenatal Diagnosis Genetic Counseling are covered as maternity care when medically necessary, see Section 11.1.8.3.

11.2.1.18. Gender dysphoria surgery and related procedures, treatment, prosthetics, or supplies when approved by DSHS in accord with WAC 388-531.

11.2.2. **Services Covered By Other Divisions In The Department Of Social And Health Services:**

11.2.2.1. Substance abuse treatment services covered through the Division of Alcohol and Substance Abuse (DASA), including inpatient detoxification services for alcohol (3-day) and drugs (5-day) with no complicating medical conditions.

11.2.2.2. Nursing facility and community based services (e.g. COPES and Personal Care Services) covered through the Aging and Disability Services Administration.

11.2.2.3. Mental health services separately purchased for all Medicaid clients by the Mental Health Division, including 24-hour crisis intervention, outpatient mental health treatment services, and inpatient psychiatric services. This shall not be construed to prevent the Contractor from purchasing covered outpatient mental health services from community mental health providers.

11.2.2.4. Health care services covered through the Division of Developmental Disabilities for institutionalized clients.

11.2.3. **Service Covered By Other State Agencies:**

Infant formula for oral feeding provided by the Women, Infants and Children (WIC) program in the Department of Health. Medically necessary nutritional supplements for infants are covered under the pharmacy benefit.

11.2.4. **Services Not Covered by Either DSHS or the Contractor:**

11.2.4.1. Medical examinations for Social Security Disability.

11.2.4.2. Services for which plastic surgery or other services are indicated primarily for cosmetic reasons.

11.2.4.3. Physical examinations required for obtaining continuing employment, insurance or governmental licensing.

11.2.4.4. Experimental and Investigational Treatment or Services, determined in accord with Section 10.16, Experimental and Investigational Services, and services associated with experimental or investigational treatment or services.

11.2.4.5. Reversal of voluntary surgically induced sterilization.

11.2.4.6. Personal Comfort Items, including but not limited to guest trays, television and telephone charges.

11.2.4.7. Biofeedback Therapy.

11.2.4.8. Diagnosis and treatment of infertility, impotence, and sexual dysfunction.

11.2.4.9. Orthoptic (eye training) care for eye conditions.

11.2.4.10. Tissue or organ transplants that are not specifically listed as covered.

11.2.4.11. Immunizations required for international travel purposes only.

11.2.4.12. Court-ordered services.

11.2.4.13. Any service provided to an incarcerated enrollee, beginning when a law enforcement officer takes the enrollee into legal custody and ending when the enrollee is no longer in legal custody .

11.2.4.14. Any service, product, or supply paid for by DSHS under its fee-for-service program only on an exception to policy basis. The Contractor may also make exceptions and pay for services it is not required to cover under this agreement.

11.2.4.15. Any other service, product, or supply not covered by DSHS under its fee-for-service program.

Quality Improvement Program Standards
Exhibit A

The Contractor shall comply with the Quality Improvement Program Standards. In the event of conflict between the Quality Improvement Program Standards and the standards in Balance Budget Act Final Rules (BBA), Washington State Patient Bill of Rights (PBOR), Health Insurance Portability and Accountability Act (HIPAA), or any other applicable state or federal statutes or regulations, the standards in BBA, PBOR, HIPAA, or any other applicable state or federal statutes or regulations, and any provision elsewhere in this agreement that implements such statutes or regulations, shall have precedence. Also see Section 7.10 Order of Precedence.

The following NCQA definitions apply to terms used in this document:

Complaint: A complaint is the same as "grievance." See 1. Definitions.

Denial a denial is the same as "action." See 1. Definitions.

Quality Improvement Program Standards
Exhibit A

NCQA STANDARDS
QUALITY MANAGEMENT AND IMPROVEMENT

QI 1 PROGRAM STRUCTURE

The organization clearly defines its quality improvement (QI) structures and processes and assigns responsibility to appropriate individuals.

ELEMENT A: Quality Improvement Program Structure

The organization's QI program structure includes the following factors:

1 a written description of the QI program

3 patient safety is specifically addressed in the program description

4 the QI program accountable to the governing body

5 an annual evaluation of the program description and updates, as necessary

6 a designated physician has substantial involvement in the QI program

7 a designated behavioral health practitioner is involved in the implementation of the behavioral health care aspects of the QI program.

8 a QI committee oversees the QI functions of the organization

9 The specific role, structure, and function of the QI committee and other committees, including meeting frequency, are addressed in the program description

10 an annual work plan

11 A description of resources that the organization devotes to the needs of the QI program.

ELEMENT C: Annual Evaluation of Quality Improvement Program

There is an annual written evaluation of the QI program that includes:

1 a description of completed and ongoing QI activities that address the quality and safety of clinical care and quality of service

2 trending of measures to assess performance in the quality and safety of clinical care and quality of service

3 analysis of the results of QI initiatives, including barrier analysis

4 evaluation of the overall effectiveness of the QI program, including progress toward influencing network-wide safe clinical practices.

QI 2 PROGRAM OPERATIONS

The organization's quality improvement program is fully operational.

Quality Improvement Program Standards
Exhibit A

NCQA STANDARDS

ELEMENT A: The QI Committee

The organization's QI committee:

1 recommends policy decisions

2 analyzes and evaluates the results of QI activities

3 institutes needed actions

4 ensures follow-up, as appropriate.

ELEMENT B: QI Committee Meeting Minutes

QI committee meeting minutes reflect all committee decisions

ELEMENT C: Practitioner Participation

Practitioners participate in the QI program through planning, design, implementation or review

ELEMENT D: QI Program Information for Practitioners and Members

Upon request, the organization makes information about its QI program available to its practitioners and members, including a description of the QI program and a report on the organization's progress in meeting its goals.

QI 3 HEALTH SERVICES CONTRACTING

The organization's contracts with individual practitioners and providers, including those making UM decisions, specify that contractors cooperate with the organization's QI program.

ELEMENT A: Practitioner Contracts

Contracts with practitioners specifically require that:

1 practitioners cooperate with QI activities

2 the organization has access to practitioner medical records, to the extent permitted by state and federal law

3 practitioners maintain the confidentiality of member information and records

ELEMENT B: Practitioner – Patient Communication

Contracts with practitioners allow open practitioner-patient communication regarding appropriate treatment alternatives. The organization does not penalize practitioners for discussing medically necessary or appropriate patient care.

ELEMENT C: Affirmative Statement

Contracts with practitioners and providers include an affirmative statement indicating that practitioners may freely communicate with patients about their treatment, regardless of benefit coverage limitations.

ELEMENT D: Provider Contracts

Contracts with organization providers specifically require that:

1 providers cooperate with QI activities

2 the organization has access to provider medical records, to the extent permitted by state and federal law.

3 providers maintain the confidentiality of member information and records

NCQA STANDARDS

ELEMENT E: Notification of Specialist Termination

Contracts with specialists and specialty group practitioners require timely notification to organization members affected by the termination of a specialist or the entire specialty group.

QI 4 AVAILABILITY OF PRACTITIONERS

The organization ensures that its network is sufficient in numbers and types of primary care and specialty care practitioners.

ELEMENT A: Cultural Needs and Preferences

The organization assesses the cultural, ethnic, racial, and linguistic needs of its members and adjusts the availability of practitioners within its network, if necessary.

ELEMENT B: Defining Primary Care Practitioners

The organization defines the practitioners who serve as primary care practitioners (PCP) within its delivery system.

ELEMENT C: Number and Geographic Distribution of Primary Care Practitioners

The organization has quantifiable and measurable standards for:

1 the number of PCPs

2 the geographic distribution of PCPs.

ELEMENT D: Annual Performance Assessment of Primary Care Practitioners

The organization annually assesses its performance against the standards established for the availability of PCPs.

ELEMENT E: Defining Specialty Care Practitioners

The organization defines which practitioners serve as high-volume specialty care practitioners (SCP).

ELEMENT F: Number and Geographic Distribution of Specialists

The organization has quantifiable and measurable standards for:

1 the number of high-volume SCPs

2 the geographic distribution of high-volume SCPs.

ELEMENT G: Annual Performance Assessment of Specialists

The organization annually analyzes its performance against the standards established for the availability of high-volume SCPs.

QI 5 ACCESSIBILITY OF SERVICES

The organization establishes mechanisms to assure the accessibility of primary care services, behavioral health services and member/enrollee services.

Quality Improvement Program Standards
Exhibit A

NCQA STANDARDS

ELEMENT A: Standards for Medical Care Access

The organization has standards for access to:

1 regular and routine care appointments

2 urgent care appointments;

3 after-hours care.

4 telephone service.

ELEMENT B: Assessment Against Medical Access Standards

The organization collects and performs an annual analysis of data to measure its performance against standards for access to:

1 regular and routine care appointments

2 urgent care appointments;

3 after-hours care.

4 telephone service.

QI 6 MEMBER SATISFACTION

The organization implements mechanisms to assure member satisfaction.

ELEMENT A: Annual Assessment

To assess member satisfaction, the organization conducts annual evaluations of member complaints and appeals.

ELEMENT B: Data Collection Methodology

The organization's complaint and appeal data collection methodology:

1 identifies the appropriate population

2 draws appropriate samples from the affected population, if a sample is used

3 collects valid data.

ELEMENT C: Identifying Opportunities for Improvement

The organization identifies opportunities for improvement, sets priorities and decides which opportunities to pursue based upon the analysis of:

1 member complaint and appeal data

2 The CAHPS® 3.0H Survey.

ELEMENT D: Reporting to Practitioners

The organization shares the results of its improvement and member satisfaction activities with practitioners and providers.

QI 7 DISEASE MANAGEMENT

The organization actively works to improve the health status of its members with chronic conditions.

ELEMENT A: Identifying Chronic Conditions

The organization identifies the two chronic conditions that its disease management (DM) programs address.

Quality Improvement Program Standards
Exhibit A

NCQA STANDARDS

ELEMENT B: Program Content

The content of the organization's programs address the following for each condition:

1 condition monitoring

2 patient adherence to the program's treatment plans

3 consideration of other health conditions

4 lifestyle issues as indicated by practice guidelines (e.g. goal-setting techniques, problem solving).

ELEMENT C: Identifying Eligible Members

Annually, the organization systematically identifies members who qualify for its programs.

ELEMENT D: Providing Eligible Members With Information

The organization provides eligible members with written program information regarding:

1 how to use the services

2 how members become eligible to participate

3 how to opt in or opt out.

ELEMENT E: Interventions Based on Stratification

The organization provides interventions to members based on stratification.

ELEMENT F: Eligible Member Participation

The organization annually measures and reports member participation rates

ELEMENT G: Informing and Educating Practitioners About Disease Management Programs

The organization has a documented process for providing practitioners with written program information, including:

1 instructions on how to use the DM services

2 how the organization works with a practitioner's members in the program.

ELEMENT H: Measuring Effectiveness

The organization employs and tracks one performance measure for each DM program. Each measurement:

1 addresses a relevant process or outcome

2 produces a quantitative result

3 is population based

4 uses data and methodology that are valid for the process or outcome measured

5 has been analyzed in comparison to a benchmark or goal.

QI 8 CLINICAL PRACTICE GUIDELINES

Guidelines removed, not applicable to Healthy Options or the State Children's Health Insurance Plan.

Quality Improvement Program Standards
Exhibit A

NCQA STANDARDS

QI 9 CONTINUITY AND COORDINATION OF MEDICAL CARE

The organization monitors the continuity and coordination of care that members receive and takes actions, as necessary, to ensure and improve continuity and coordination of care across the health care network.

ELEMENT A: Continuity and Coordination of Medical Care

The organization annually collects data about the coordination of medical care across settings or transitions in care.

ELEMENT B: Identifying Opportunities for Improvement of Medical Care Coordination

The organization identifies opportunities to improve coordination of medical care. There is documentation of the following factors:

1 quantitative and causal analysis of data to identify improvement opportunities

2 identification and selection of at least two opportunities for improvement.

ELEMENT C: Medical Coordination Issues

The organization takes action to improve coordination of medical care.

ELEMENT D: Notification of Primary Care Practitioner Termination

Requirement removed, not applicable to Healthy Options or the State Children's Health Insurance Plan.

QI 11 CLINICAL QUALITY IMPROVEMENTS

Requirement removed, not applicable to Healthy Options or the State Children's Health Insurance Plan.

QI 12 SERVICE QUALITY IMPROVEMENTS

Requirement removed, not applicable to Healthy Options or the State Children's Health Insurance Plan.

QI 13 STANDARDS FOR MEDICAL RECORD DOCUMENTATION

The organization requires medical records to be maintained in a manner that is current, detailed and organized, and which permits effective and confidential patient care and quality review.

ELEMENT A: Medical Record Criteria

The organization has policies and distributes the policies to practice sites that address:

1 confidentiality of medical records

2 medical record documentation standards

3 an organized medical record keeping system and standards for availability of medical records

4 performance goals to assess the quality of medical record keeping.

ELEMENT B: Documentation Standards

The organization's medical record standards or their predecessors have been in place for at least 12 months

ELEMENT C: Improving Medical Record Keeping

The organization implements a method(s) to improve medical record keeping

Quality Improvement Program Standards
Exhibit A

NCQA STANDARDS

QI 14 DELEGATION OF QI

If the organization delegates any QI activities, there is evidence of oversight of the delegated activity.

ELEMENT A: Written Delegation Agreement

There is a mutually agreed-upon document that describes all delegated activities

ELEMENT B: Specific Delegated Activities

The delegation document describes:

1 the responsibilities of the organization and the delegated entity

2 the delegated activities

3 at least semiannual reporting to the organization

4 the process by which the organization evaluates the delegated entity's performance

5 the remedies, including revocation of the delegation, available to the organization if the delegated entity does not fulfill its obligations.

ELEMENT C: Provisions for Protected Health Information

If the delegation arrangement includes the use of protected health information by the delegate, the delegation document also includes the following provisions:

1 a list of the allowed uses of protected health information

2 a description of delegate safeguards to protect the information from inappropriate use of further disclosure

3 a stipulation that the delegate ensures that subdelegates have similar safeguards

4 a stipulation that the delegate provide individuals with access to their protected health information

5 a stipulation that the delegate informs the organization if inappropriate uses of the information occur

6 a stipulation that the delegate ensures protected health information is returned, destroyed or protected if the delegation agreement ends.

ELEMENT D: Approval of QI Program

Annually, the organization approves its delegates QI program.

ELEMENT E: Pre-Delegation Evaluation

For delegation agreements that have been in effect for less than 12 months, the organization evaluated delegate capacity before delegation began.

ELEMENT F: Annual Evaluation

For delegation arrangements in effect for 12 months or longer, the organization annually evaluated delegate performance against its expectations and NCQA standards.

ELEMENT G: Reporting

For delegation arrangements in effect 12 months or longer, the organization evaluated regular reports, as specified in Element B.

Quality Improvement Program Standards
Exhibit A

NCQA STANDARDS

ELEMENT H: Opportunities for Improvement

For delegation arrangements that have been in effect for more than 12 months, at least once each of the past 2 years that delegation has been in effect, the organization has identified and followed up on opportunities for improvement, if applicable.

UTILIZATION MANAGEMENT

UM 1 Utilization Management Structure

The organization clearly defines the structures and processes within its utilization management (UM) program and assigns responsibility appropriate individuals.

ELEMENT A: Written Program Description

The organization's UM program description includes the following factors:

1 program structure

2 behavioral health care aspects of the program

3 involvement of a designated senior physician in UM program implementation

4 involvement of a designated behavioral health care practitioner in the implementation of the behavioral health care aspects of the UM program

5 scope of the program and the processes and information sources used to make determinations of benefit coverage and medical necessity.

ELEMENT C: Physician Involvement

A senior physician is actively involved in implementing the organization's UM program.

ELEMENT D: Behavioral Health Practitioner Involvement

A behavioral health practitioner is actively involved in implementing the behavioral health aspects of the UM program.

ELEMENT E: Annual Evaluation

The organization annually evaluates and updates the UM program, as necessary.

UM 2 Clinical Criteria for UM Decisions

To make utilization decisions, the organization uses written criteria based on sound clinical evidence and specifies procedures for appropriately applying the criteria.

ELEMENT A: Evidence-Based, Written Criteria

The organization has written UM decision-making criteria that are objective and based on medical evidence.

Quality Improvement Program Standards
Exhibit A

NCQA STANDARDS

ELEMENT B: Applying Utilization Management Criteria

The organization has written procedures for applying UM criteria based on:

1 individual needs

2 assessment of the local delivery system.

ELEMENT C: Involvement of Appropriate Practitioners

The organization involves appropriate practitioners in developing, adopting and reviewing criteria applicability

ELEMENT D: Length of Time Criteria Are in Place

The organization's UM criteria have been in place for at least 12 months

ELEMENT E: Reviewing and Updating Criteria

The organization has a process for periodically reviewing and updating UM criteria and the procedures for applying them.

ELEMENT F: Availability of Criteria

The organization states in writing how practitioners can obtain UM criteria, and makes the criteria available to its practitioners upon request.

ELEMENT G: Consistency in Applying Criteria

The organization annually evaluates the consistency with which health care professionals involved in UM apply criteria in decision making and acts on opportunities for improvement, if applicable.

UM 4 Appropriate Professionals

Qualified licensed health professionals assess the clinical information used to support UM decisions.

ELEMENT A: Licensed Health Professionals

The organization has written procedures:

1 requiring appropriately licensed professionals to supervise all medical necessity decisions

ELEMENT B: Use of Practitioners for UM Decisions

The organization has a written job description with qualifications for practitioners who review denials of care based on medical necessity that requires:

1 education, training or professional experience in medical or clinical practice

2 current license to practice without restriction.

ELEMENT C: Non-Behavioral Health Practitioner Review of Denials

The organization ensures that a physician, dentist or pharmacist, as appropriate, reviews any non-behavioral health denial of care based on medical necessity.

ELEMENT D: Behavioral Health Practitioner Review of Denials

The organization ensures that a physician, appropriate behavioral health practitioner or pharmacist, as appropriate, reviews any behavioral health denial of care based on medical necessity.

Quality Improvement Program Standards
Exhibit A

NCQA STANDARDS

ELEMENT E: Use of Board-Certified Consultants

The organization has written procedures for using board-certified consultants to assist in making medical necessity determinations.

UM 5 Timeliness of UM Decisions

The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of the situation.

ELEMENT A: Timeliness of Decision Making for Non-Behavioral Health UM Decisions

The organization adheres to the following standards for timeliness of UM decision making:

1 for nonurgent pre-service decisions, the organization makes decisions within 15 calendar days of receipt of the request [HCA & MAA require nonurgent, pre-service decisions within 14 calendar days]

2 for urgent pre-service decisions, the organization makes decisions within 72 hours of receipt of the request

3 for urgent concurrent review, the organization makes decisions within 24 hours of receipt of the request

4 for post-service decisions, the organization makes decisions within 30 calendar days of receipt of the request.

ELEMENT B: Notification of Non-Behavioral Health Decisions

The organization adheres to the following standards for notification of non-behavioral health UM decision making:

1 for nonurgent pre-service approval decisions, the organization gives oral, electronic or written notification of the decision to practitioners and members within 15 calendar days of the request [HCA & MAA require nonurgent, pre-service decisions within 14 calendar days]

2 for nonurgent pre-service denial decisions, the organization gives electronic or written notification of the decision to practitioners and members within 15 calendar days of the request

3 for urgent pre-service approval decisions, the organization gives oral, electronic or written notification of the decision to practitioners and members within 72 hours of the request

4 for urgent pre-service denial decisions, the organization gives electronic or written notification of the decision to practitioners and members within 72 hours of the request

5 for urgent concurrent approval decisions, the organization gives oral, electronic or written notification of the decision to practitioners and members within 24 hours of the request

6 for urgent concurrent denial decisions, the organization gives electronic or written notification of the decision to practitioners and members within 24 hours of the request

7 for post-service denial decisions, the organization gives electronic or written notification of the decision to practitioners and members within 30 calendar days of the request.

ELEMENT C: Timeliness of Decision Making for Behavioral Health UM Decisions

The organization adheres to the following standards for timeliness of behavioral health UM decision making:

1 for nonurgent pre-service decisions, the organization makes decisions within 15 calendar days of receipt of the request [HCA & MAA require nonurgent, pre-service decisions within 14 calendar days]

NCQA STANDARDS

2 for urgent pre-service decisions, the organization makes decisions within 72 hours of receipt of the request

3 for urgent concurrent review, the organization makes decisions within 24 hours of receipt of the request

4 for post-service decisions, the organization makes decisions within 30 calendar days of receipt of the request.

ELEMENT D: Notification of Behavioral Health Decisions

The organization adheres to the following standards for notification of behavioral health UM decision making:

1 for nonurgent pre-service approval decisions, the organization gives oral, electronic or written notification of the decision to practitioners and members within 15 calendar days of the request

2 for nonurgent pre-service denial decisions, the organization gives electronic or written notification of the decision to practitioners and members within 15 calendar days of the request

3 for urgent pre-service approval decisions, the organization gives oral, electronic or written notification of the decision to practitioners and members within 72 hours of the request

4 for urgent pre-service denial decisions, the organization gives electronic or written notification of the decision to practitioners and members within 72 hours of the request

5 for urgent concurrent approval decisions, the organization gives oral, electronic or written notification of the decision to practitioners and members within 24 hours of the request

6 for urgent concurrent denial decisions, the organization gives electronic or written notification of the decision to practitioners and members within 24 hours of the request

7 for post-service denial decisions, the organization gives electronic or written notification of the decision to practitioners and members within 30 calendar days of the request.

UM 6 Clinical Information

When making a determination of coverage based on medical necessity, the organization obtains relevant clinical information and consults with the treating physician.

ELEMENT A: Information for UM Decision Making

The organization has a written description that identifies the information that is needed to support UM decision making in place for at least 12 months.

ELEMENT C: Non-Behavioral Health Documentation of Relevant Information

There is documentation that relevant clinical information is gathered consistently to support non-behavioral health UM decision making.

ELEMENT D: Behavioral Health Documentation of Relevant Information

There is documentation that relevant clinical information is gathered consistently to support behavioral health UM decision making.

Quality Improvement Program Standards
Exhibit A

NCQA STANDARDS

ELEMENT E: Transition to Other Care

The organization assists with a member's transition to other care, if necessary, when benefits end.

UM 7 Denial Notices

The organization clearly documents and communicates the reasons for each denial.

ELEMENT A: Notification of the Availability of Physician, Appropriate Behavioral Health or Pharmacist Reviewers

The organization notifies practitioners of:

1 its policy for making a reviewer available to discuss any UM denial decision

2 how to contact a reviewer.

ELEMENT B: Providing Practitioners the Opportunity to Discuss Non-Behavioral Health Denial Decisions with a Physician or Pharmacist Reviewer

The organization provides practitioners with the opportunity to discuss any non-behavioral health UM denial decision with a physician or pharmacist reviewer.

ELEMENT C: Reason for Non-Behavioral Health Denial

The organization provides written notification that contains the following:

1 the specific reason(s) for the denial, in easily understandable language

2 a reference to the benefit provision, guideline, protocol or other similar criterion on which the denial decision is based

3 notification that the member can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision was based, upon request.

ELEMENT D: Non-Behavioral Health Notification of Appeal Rights and Process

The organization provides written notification that contains the following:

1 description of appeal rights, including the right to submit written comments, documents or other information relevant to the appeal

2 explanation of the appeal process, including the right to member representation and time frames for deciding appeals

3 if a denial is an urgent pre-service or urgent concurrent denial, a description of the expedited appeal process.

ELEMENT E: Providing Practitioners the Opportunity to Discuss Behavioral Health Denial Decisions with a Physician, Appropriate Behavioral Health or Pharmacist Reviewer.

The organization provides practitioners with the opportunity to discuss any behavioral health UM denial decision with a physician, appropriate behavioral health or pharmacist reviewer.

NCQA STANDARDS

ELEMENT F: Reason for Behavioral Health Denial

The organization provides written notification that contains the following:

1 the specific reason(s) for the denial, in easily understandable language

2 a reference to the benefit provision, guideline, protocol or other similar criterion on which the denial decision was based

3 notification that the member can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision was based, upon request.

ELEMENT G: Behavioral Health Notification of Appeal Rights and Appeal process

The organization provides written notification that contains the following:

1 description of appeal rights, including the right to submit written comments, documents or other information relevant to the appeal

2 explanation of the appeal process, including the right to member representation and time frames for deciding appeals

3 if a denial is an urgent pre-service or urgent concurrent denial, a description of the expedited appeal process.

UM 8 Policies for Appeals

The organization has written policies and procedures for the thorough, appropriate, and timely resolution of member appeals. Note: For BH & PEBB, Contractors are required to follow the Washington State "Patient Bill of Rights" (PBOR).

UM 9 Appropriate Handling of Appeals

The organization adjudicates member appeals in a thorough, appropriate and timely manner. Note: For BH & PEBB, Contractors are required to follow the Washington State "Patient Bill of Rights" (PBOR).

UM 10 Evaluation of New Technology

The organization evaluates the inclusion of new technologies and the new application of existing technologies in the benefit package. This includes medical and behavioral procedures, pharmaceuticals and devices.

ELEMENT A: Written Process

The organization's written process for evaluating new technologies and the new application of existing technologies for inclusion in its benefit package includes an evaluation of the following factors:

1 medical technologies

2 behavioral health procedures

3 pharmaceuticals

4 devices.

ELEMENT C: Implementation of Evaluated New Technology

The organization implements a decision on coverage from its assessment of new technologies and new applications of existing technologies or from review of special cases.

Quality Improvement Program Standards
Exhibit A

NCQA STANDARDS

UM 12 Emergency Services

The organization provides, arranges for or otherwise facilitates all needed emergency services, including appropriate coverage of costs.

ELEMENT A: Emergency Services Policies and Procedures

The organization's policies and procedures require:

1 coverage of emergency services to screen and stabilize the member without prior approval where a prudent layperson, acting reasonably, would have believed an emergency medical condition existed

2 coverage of emergency services if an authorized representative, acting for the organization, has authorized the provision of emergency services.

UM 13 Procedures for Pharmaceutical Management

The organization ensures that its procedures for pharmaceutical management, if any, promote the clinically appropriate use of pharmaceuticals.

ELEMENT A: Pharmaceutical Management Policies and Procedures

The organization's policies and procedures for pharmaceutical management include:

1 the criteria used to adopt pharmaceutical management procedures

2 a process that uses clinical evidence from appropriate external organizations.

UM 14 Ensuring Appropriate Utilization

The organization facilitates the delivery of appropriate care and monitors the impact of its utilization management program to detect and correct potential under - and overutilization of services.

ELEMENT A: Relevant Utilization Data

The organization chooses at least four relevant types of utilization data, including one type related to behavioral health to monitor for each product line.

ELEMENT B: Under/Overutilization Thresholds

The organization sets thresholds to identify under - and overutilization for the four chosen data types, including behavioral health data, by product line.

ELEMENT C: Monitoring Data

Annually, the organization monitors the performance of the four chosen data types, including behavioral health data, against established thresholds for each product line to detect under - and overutilization.

ELEMENT D: Quantitative Data Analysis

Annually, the organization analyzes the performance of the four chosen data types, including behavioral health data, against established thresholds for each product line to detect under - and overutilization.

NCQA STANDARDS

ELEMENT E: Qualitative Data Analysis

The organization conducts qualitative analysis to determine the cause and effect of all data not within thresholds.

ELEMENT F: Site-Level Monitoring

The organization analyzes data not within threshold by practice sites.

ELEMENT G: Interventions

The organization takes action to address identifies problems of under - and overutilization.

ELEMENT H: Evaluating the Effectiveness of Interventions

The organization measures the effectiveness of interventions to address under - and overutilization.

ELEMENT I: Affirmative Statement Regarding Incentives

The organization distributes a statement to all its practitioners, providers, members and employees affirming that:

1 UM decision making is based only on appropriateness of care and service and existence of coverage

2 the organization does not specifically reward practitioners or other individuals for issuing denials of coverage or service care

3 financial incentives for UM decision makers do not encourage decisions that result in underutilization.

UM 16 Delegation of UM

If the managed care organization delegates any UM activities, there is evidence of oversight of the delegated activity.

ELEMENT A: Written Delegation Agreement

There is a mutually agreed-upon document that describes all delegated activities.

ELEMENT B: Specific Delegated Activities

The delegation document describes:

1 the responsibilities of the organization and the delegated entity

2 the delegated activities

3 at least semi-annual reporting to the organization

4 the process by which the organization evaluates the delegated entity's performance

5 the remedies, including revocation of the delegation, available to the organization if the delegated entity does not fulfill its obligations.

ELEMENT C: Provision for Protected Health Information

If the delegation arrangement includes the use of protected health information by the delegate, the delegation document also includes the following provisions:

1 a list of the allowed uses of protected health information

2 a description of delegate safeguards to protect the information from inappropriate use or further disclosure

3 a stipulation that the delegate will ensure that subdelegates have similar safeguards

NCQA STANDARDS

4 a stipulation that the delegate will provide individuals with access to their protected health information

5 a stipulation that the delegate will inform the organization if inappropriate uses of the information occur

6 a stipulation that the delegate will ensure protected health information is returned, destroyed or protected if the delegation agreement ends.

ELEMENT D: Approval of UM Program

Annually, the organization approves its delegate's UM program.

ELEMENT E: Pre-Delegation Evaluation

For delegation agreements that have been in effect for less than 12 months, the organization evaluated delegate capacity before delegation began.

ELEMENT F: Annual Evaluation

For delegation arrangements in effect 12 months or longer, the organization annually evaluated delegate performance against its expectations and NCQA standards.

ELEMENT G: Reporting

For delegation arrangements in effect 12 months or longer, the organization evaluated regular reports, as specified in Element B.

ELEMENT H: Opportunities for Improvement

For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that delegation has been in effect, the organization has identifies and followed up on opportunities for improvement, if applicable.

CREDENTIALING AND RECREDENTIALING

CR 1 Credentialing Policies

The organization documents the mechanisms for the credentialing and recredentialing of licensed independent practitioners with whom it contracts or employs and who fall within its scope of authority and action.

ELEMENT A: Practitioner Credentialing Guidelines

The organization's credentialing policies and procedures specify the types of practitioners to credential and recredential.

ELEMENT B: Criteria and Verification Sources

The organization's policies and procedures specify:

1 the criteria for credentialing and recredentialing

2 the verification sources used.

Quality Improvement Program Standards
Exhibit A

NCQA STANDARDS

ELEMENT C: Policies and Procedures

The organization's policies and procedures include the following factors:

1 the process to delegate credentialing or recredentialing;

2 the process used to ensure that credentialing and recredentialing are conducted in a non-discriminatory manner

3 the process for notifying a practitioner about any information obtained during the organization's credentialing process that varies substantially from the information provided to the organization by the practitioner

4 the process to ensure that practitioners are notified of the credentialing or recredentialing decision within 60 calendar days of the committee's decision

5 the medical director's or other designated physician's direct responsibility and participation in the credentialing program

6 the process used to ensure the confidentiality of all information obtained in the credentialing process, except as otherwise provided by law

7 the process for making credentialing and recredentialing decisions.

ELEMENT D: Practitioners Rights

The organization's policies and procedures include the following practitioner rights:

1 the right of practitioners to review information submitted to support their credentialing applications

2 the right of practitioner's to correct erroneous information;

3 the right of practitioners, upon request, to be informed of the status of their credentialing or recredentialing application

4 notification of these rights.

CR 2 Credentialing Committee

The organization designates a credentialing committee that uses a peer review process to make recommendations regarding credentialing decisions.

ELEMENT A: Credentialing Committee

The Credentialing Committee includes representation from a range of participating practitioners.

ELEMENT B: Credentialing Committee Decisions

The Credentialing Committee has the opportunity to review the credentials of all practitioners and offer advice, which the organization considers.

CR 3 Initial Credentialing Verification

The organization verifies credentialing information through primary sources, unless otherwise indicated.

ELEMENT A: Initial Primary Source Verification

The organization verifies that the following factors are present and within the prescribed time limits:

1 a current, valid license to practice

2 a valid DEA or CDS certificate, if applicable

3 education and training including board certification if the practitioner states on the application that he/she is board certified

NCQA STANDARDS

4 work history

5 history of professional liability claims that resulted in settlements or judgments paid by on behalf of the practitioner.

CR 4 Application and Attestation

The applicant completes an application for membership that includes a current and signed attestation regarding the applicant's health status and any history of loss or limitation of licensure or privileges:.

ELEMENT A: Contents of the Application

The application includes a current and signed attestation and addresses:

1 reasons for any inability to perform the essential functions of the position, with or without accommodation

2 lack of present illegal drug use

3 history of loss of license and felony convictions

4 history of loss or limitation of privileges or disciplinary activity

5 current malpractice insurance coverage

6 the correctness and completeness of the application.

CR 5 Initial Sanction Information

There is documentation that before making a credentialing decision the organization has received information on sanctions.

ELEMENT A: Sanctions

In an NCQA review of credentialing files, two factors are present and within 180 calendar day time limit:

1 state sanctions, restrictions on licensure and/ or limitations on scope of practice

2 Medicare and Medicaid sanctions.

CR 7 Recredentialing Verification

The organization formally recredentials its practitioners at least every 36 months through information verified from primary sources, unless otherwise indicated.

ELEMENT A: Recredentialing Verification

The organization verifies the following factors within the prescribed time limits:

1 a current valid state license to practice

2 a valid DEA or CDS certificate, as applicable

3 board certification, if the practitioner states that he/she is board certified

4 history of professional liability claims that resulted in settlements or judgments paid by or on behalf of the practitioner.

Quality Improvement Program Standards
Exhibit A

NCQA STANDARDS

ELEMENT B: Correctness/Completeness of the Application

An applicant completes an application for membership that includes a current and signed attestation with the following factors:

1 reasons for any inability to perform the essential functions of the position, with or without accommodation

2 lack of present illegal drug use

3 history of loss or limitation of privileges or disciplinary activity

4 current malpractice insurance coverage

5 correctness and completeness of the application.

ELEMENT C: Recredentialing Cycle Length

The length of the recredentialing cycle is within the required 36 month time frame.

CR 8 Recredentialing Sanction Information

There is documentation that before making a recredentialing decision, the organization has received information on sanctions.

ELEMENT A: Sanction Information

In an NCQA review of recredentialing files, two elements are present and within 180 calendar day time limit:

1 state sanctions, restrictions on licensure and/or limitations on scope of practice

2 Medicare and Medicaid sanctions.

ELEMENT B: Recredentialing Cycle Length

In a review of a sample of the organization's recredentialing files, the length of the recredentialing cycle is within the 3 year (36 month) time frame.

CR 9 Performance Monitoring

The organization incorporates information from quality improvement activities and member complaints in its recredentialing decision-making process for primary care practitioners and high-volume behavioral health care practitioners.

ELEMENT A: Decision-Making Process

The organization includes information from quality improvement activities and member complaints in its recredentialing decision-making process for PCPs and high-volume behavioral health care practitioners.

CR 10 Ongoing Monitoring of Sanctions and Complaints

The organization develops and implements policies and procedures for ongoing monitoring of practitioner sanctions and complaints between recredentialing cycles and takes appropriate action against practitioners when it identifies occurrences of poor quality.

ELEMENT A: Written Policy and Procedures

The organization has a written policy and procedure that addresses the ongoing monitoring of:

1 Medicare and Medicaid sanctions

NCQA STANDARDS

2 sanctions and limitations on licensure

3 complaints.

ELEMENT C: Implementing ongoing Monitoring

The organization collects and reviews information from:

1 Medicare and Medicaid sanctions

2 sanctions and limitations on licensure

3 complaints.

ELEMENT D: Appropriate Interventions

The organization implements appropriate interventions when it identifies occurrences of poor quality, when appropriate.

CR 11 Notification to Authorities and Practitioner Appeal Right

When an organization has taken actions against a practitioner for quality reasons, it offers the practitioner a formal appeal process and reports the action to the appropriate authorities.

ELEMENT A: Written Policy and Procedures

The organization has policies and procedures for:

1 the range of actions available to the organization

2 procedures for reporting to authorities

3 a well-defined appeal process

4 making the appeal process known to practitioners.

ELEMENT B: Contract Suspension or Termination

There is documentation that the organization reports practitioner suspension or termination to the appropriate authorities.

ELEMENT C: Practitioner Approval Process

The organization has an appeal process for instances in which it chooses to alter the condition of the practitioner's participation based on issues of quality of care and/or service. The organization informs practitioners of the appeal process.

CR 12 Assessment of Organizational Providers

The organization has written policies and procedures for the initial and ongoing assessment of providers with which it intends to contract.

ELEMENT A: Review and Approval of Provider

The organization's policy for credentialing of health care delivery providers specifies that it:

1 confirms that the provider is in good standing with state and federal regulatory bodies

2 confirms that the provider has been reviewed and approved by an accrediting body

NCQA STANDARDS

3 conducts an on-site quality assessment, if there is no accreditation status

4 confirms that the provider continues to be in good standing with state and federal regulatory bodies and, if applicable, is reviewed and approved by an accrediting body at least every 3 years.

ELEMENT B: Medical Providers

The organization includes at least the following medical providers:

1 hospitals

2 home health agencies

3 skilled nursing facilities

4 free-standing surgical centers.

ELEMENT D: Assessing Medical Care Providers

The organization has documentation of assessment of contracted medical health care delivery providers.

CR 13 Delegation of Credentialing

If the organization delegates any credentialing and recredentialing activities, there is evidence of oversight of the delegated activity.

ELEMENT A: Written Delegation Agreement

There is a mutually agreed-upon document that describes all delegated activities.

ELEMENT B: Specific Delegated Activities

The delegation document describes:

1 the responsibilities of the organization and the delegated entity

2 the delegated activities

3 at least semi-annual reporting to the organization

4 the process by which the organization evaluates delegated entity's performance

5 the remedies, including revocation of the delegation, available to the organization if the delegated entity does not fulfill its obligations.

ELEMENT C: Provisions for Protected Health Information

If the delegation arrangement includes the use of protected health information by the delegate, the delegation document also includes the following provisions:

1 a list of the allowed uses of protected health information

2 a description of delegate safeguards to protect the information from inappropriate use or further disclosure

3 a stipulation that the delegate will ensure that subdelegates have similar safeguards

4 a stipulation that the delegate will provide individuals with access to their protected health information

NCQA STANDARDS

5 a stipulation that the delegate will inform the organization if inappropriate uses of the information occur

6 a stipulation that the delegate will ensure protected health information is returned, destroyed or protected if the delegation agreement ends.

ELEMENT D: Right to Approve and to Terminate

The organization retains the right, based on quality issues, to approve, suspend and terminate individual practitioners, providers and sites in situations where it has delegated decision making. This right is reflected in the delegation documents.

ELEMENT E: Pre-Delegation Evaluation

For delegation agreements that have been in effect for less than 12 months, the organization evaluated delegate capacity before delegation began.

ELEMENT F: Annual File Audit

For delegation arrangements in effect for 12 months or longer, the organization has audited files against NCQA standards for each year that the delegation has been in effect.

ELEMENT G: Annual Evaluation

For delegation arrangements in effect for more than 12 months, the organization has performed an annual substantive evaluation of delegated activities against delegated NCQA standards and organizational expectations.

ELEMENT H: Reporting

For delegation arrangements in effect for 12 months or longer, the organization evaluated regular reports, as specified in Element B.

ELEMENT I: Opportunities for Improvement

For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that delegation has been in effect, the organization has identifies and followed up on opportunities for improvement, if applicable.

MEMBERS' RIGHTS AND RESPONSIBILITIES

RR 1 Statement of Members' Rights and Responsibilities

The organization has a written policy that states its commitment to treating members in a manner that respects their rights and its expectations of members' responsibilities.

ELEMENT B: Statement of Members' Rights and Responsibilities

The organization's members' rights and responsibilities policy states that members have:

1 a right to receive information about the organization, its services, its practitioners and providers and members' rights and responsibilities

NCQA STANDARDS

2 a right to be treated with respect and recognition of their dignity and right to privacy

3 a right to participate with practitioners in decision-making regarding their health care

4 a right to a candid discussions of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage

5 a right to voice complaints or appeals about the organization or the care provided

7 a responsibility to provide information (to the extent possible) that the organization and its practitioners and providers need in order to care

8 a responsibility to follow plans and instructions for care that they have agreed on with their practitioners

9 a responsibility to understand their health care problems and participate in developing mutually agreed upon treatment goals to the degree possible.

RR 2 Distribution of Rights Statements to Members and Practitioners

The organization distributes its policy on members' rights and responsibilities to its members and participating practitioners.

ELEMENT A: Distribution of Rights Statement to Members and Practitioners

The organization distributes its members' rights and responsibilities statement to:

1 existing members

2 new members

3 existing practitioners

4 new practitioners.

RR 3 Policies for Complaints and Appeals

The organization has written policies and procedures for the thorough, appropriate and timely resolution of member complaints and appeals. Note: For BH & PEBB, Contractors are required to follow the Washington State "Patient Bill of Rights" (PBOR).

RR 4 Subscriber Information

The organization provides each subscriber with information needed to understand benefit coverage and obtain care.

ELEMENT A: Subscriber Information

The organization provides written information to its subscriber addresses the following factors:

1 benefits and services included in, and excluded from, coverage

2 pharmaceutical management procedures, if they exist

3 copayments and other charges for which the member is responsible

4 restrictions on benefits that apply to services obtained outside the organization's system or service area

6 how to obtain information about practitioners who participate in the organization

NCQA STANDARDS

7 how to obtain primary care services, including points of access

8 how to obtain specialty care, behavioral health services and hospital services

9 how to obtain care after normal office hours

10 how too obtain emergency care, including the organization's policy on when to directly access emergency care or use 911 services

11 how to obtain care and coverage when out of the organization's service area

13 Requirement removed, not applicable to Healthy Options or the State Children's Health Insurance Plan.

14 how the MCO evaluates new technology for inclusion as a covered benefit.

ELEMENT B: Translation Services

The organization provides translation services within its member services telephone function based on the linguistic needs of its members.

RR 5 Privacy and Confidentiality

The organization protects the confidentiality of member information and records.

ELEMENT A: Adopting Written Policies

The organization adopts written policies and procedures regarding protected health information (PHI) that addresses:

1 information included in notifications of privacy practices

2 access to PHI

3 the process for members to request restrictions on use/disclosure of PHI

4 the process for members to request amendments to PHI

5 the process for members to request an accounting of disclosures of PHI

6 internal protection of oral, written and electronic information across the organization.

ELEMENT B: Special Protection for PHI Sent to Plan Sponsors

The organization's policies and procedures prohibit sharing members' PHI with any sponsor without certification that the plan sponsor's documents have been amended to incorporate the following provisions and the plan sponsor agrees to:

1 not use or disclose PHI other than as permitted by the plan documents or required by law

2 ensure that agents and subcontractors of the employer or plan sponsor agree to the same restrictions and conditions as the employer or plan sponsor with regard to PHI

RR 6 Marketing Information

The organization ensures that communications with prospective members correctly and thoroughly represent the benefits and operating procedures of the organization.

NCQA STANDARDS

ELEMENT A: Summary Statement of UM

Marketing materials for prospective members contain a summary statement of how the organization's utilization management UM procedures work.

ELEMENT B:

All organization materials and presentations accurately describe:

1 covered benefits

2 noncovered benefits

3 practitioner and provider availability

4 potential restrictions

ELEMENT C: Communicating with Prospective Members

The organization communicates to prospective members, in easy-to-understand language, a summary of its policies and practices regarding the collection, use and disclosure of protected health information. Communication with prospective members includes the following six factors:

1 inclusions in routine notifications of privacy practices

2 the right to approve release of information (use of authorization)

3 access to medical records

4 protection of oral, written and electronic information across the organization

5 the use of measurement data

6 information for employers.

RR 7 Delegation of RR

If the managed care organization delegates any RR activities, there is evidence of oversight of the delegated activity.

ELEMENT A: Written Delegation Agreement

There is a mutually agreed-upon document that describes all delegated activities.

ELEMENT B: Specific Delegated Activities

The delegation document describes:

1 the responsibilities of the organization and the delegated entity

2 the delegated activities

3 at least semi-annual reporting to the organization

4 the process by which the organization evaluates delegated entity's performance

5 the remedies, including revocation of the delegation, available to the organization if the delegated entity does not fulfill its obligations.

Quality Improvement Program Standards
Exhibit A

NCQA STANDARDS

ELEMENT C: Provisions for Protected Health Information

If the delegation arrangement includes the use of protected health information by the delegate, the delegation document also includes the following provisions:

1 a list of the allowed uses of protected health information

2 a description of delegate safeguards to protect the information from inappropriate use or further disclosure

3 a stipulation that the delegate will ensure that subdelegates have similar safeguards

4 a stipulation that the delegate will provide individuals with access to their protected health information

5 a stipulation that the delegate will inform the organization if inappropriate uses of the information occur

6 a stipulation that the delegate will ensure protected health information is returned, destroyed or protected if the delegation agreement ends.

ELEMENT D: Pre-Delegation Evaluation

For delegation agreements that have been in effect for less than 12 months, the organization evaluated delegate capacity before delegation began.

ELEMENT E: Annual Evaluation

For delegation arrangements in effect for more than 12 months, the organization has performed an annual substantive evaluation of delegated activities against delegated NCQA standards and organizational expectations.

ELEMENT F: Reporting

For delegation arrangements in effect for 12 months or longer, the organization evaluated regular reports, as specified in Element B.

ELEMENT G: Opportunities for Improvement

For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that delegation has been in effect, the organization has identifies and followed up on opportunities for improvement, if applicable.

PREVENTIVE HEALTH SERVICES - Requirement removed, not applicable to Healthy Options or the State Children's Health Insurance Plan.

Exhibit B PLACEHOLDER

EXHIBIT 10.18

AMENDMENT OF
HEALTH NET – MOLINA MEDI-CAL HEALTH SERVICES AGREEMENTS FOR
LOS ANGELES, RIVERSIDE AND SAN BERNARDINO COUNTIES

Modification of termination provisions

This is an amendment of the three substantially identical Health Services Agreements for Los Angeles, Riverside and San Bernardino counties (the "Agreements") entered into by and between Molina Healthcare of California ("Molina") and Health Net of California, Inc. ("Health Net").

The parties hereby amend the Agreements as follows:

1. **Modification of termination without cause provision.** Section 7.04, Termination Without Cause, of the Agreements is hereby deleted in its entirety and left intentionally blank.

2. **Modification of cure period for breach of contract provision.** Section 7.01(ii) and Section 7.02(ii) of the Agreements are hereby modified to extend the specified cure period from 30 to 90 days.

3. **Modification of the Term of the Agreement. Article 6 of the Agreements are hereby amended to read as follows:**

   "Unless sooner terminated as set forth in Article 7 below, the term of this Agreement shall commence concurrently with the effective date of the Medi-Cal Agreement and shall continue for the full term of the Medi-Cal Agreement and any extensions thereto, and/or any other contract and extensions thereto held by Health Net covering Medicaid beneficiaries in Los Angeles County arising from its bidding in the next reprocurement of the Commercial Plan Contract under the Two-Plan Model Medi-Cal Managed Care Program."

4. **Effective date of Amendment**. This Amendment is effective on the date of Health Net's signature below; subject to the parties entering into the Exclusivity and Confidentiality Agreement dated 10/16, 2003. The parties understand and agree that this amendment shall be of no force or effect if the Exclusivity and Confidentiality Agreement is not fully executed by the parties.

MOLINA HEALTHCARE OF CALIFORNIA

By: /s/ PATRICIA DINSMORE JENNINGS

Patricia Dinsmore Jennings
Chief Executive Officer

Dated: 10/16/03

HEALTH NET OF CALIFORNIA, INC.

By: /s/ CHRIS WING

Chris Wing
President

Dated: 10/28/03

EXHIBIT 23.1

CONSENT OF ERNST & YOUNG LLP, INDEPENDENT AUDITOR

We consent to the incorporation by reference in the Registration Statement (Form S-8) pertaining to the Molina Healthcare, Inc. 2000 Omnibus Stock and Incentive Plan, 2002 Equity Incentive Plan and 2002 Employee Stock Purchase Plan, of our report dated January 30, 2004, with respect to the consolidated financial statements of Molina Healthcare, Inc. included in the Annual Report (Form 10-K) for the year ended December 31, 2003.

/s/ ERNST & YOUNG LLP

Los Angeles, California
February 13, 2004

EXHIBIT 31.1

CERTIFICATION PURSUANT TO
RULES 13a-14(a)/15d-14(a)
UNDER THE SECURITIES EXCHANGE ACT OF 1934,
AS AMENDED

I, J. Mario Molina, M.D., certify that:

1. I have reviewed the report on Form 10-K for the year ended December 31, 2003 of Molina Healthcare, Inc.;

2. Based on my knowledge, the report does not contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by the report;

3. Based on my knowledge, the financial statements, and other financial information included in the report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in the report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Rule 13a-15(e) and 15d-15(e) of the Securities Exchange Act of 1934, as amended), and internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) of the Securities Exchange Act of 1934, as amended), for the registrant and have:

   (a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;

   (b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

   (c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in the report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by the report based on such evaluation; and

   (d) Disclosed in the report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and to the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

   (a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report information; and

   (b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

February 19, 2004

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

J. Mario Molina, M.D.
Chairman of the Board,
Chief Executive Officer and President

EXHIBIT 31.2

CERTIFICATION PURSUANT TO
RULES 13a-14(a)/15d-14(a)
UNDER THE SECURITIES EXCHANGE ACT
OF 1934, AS AMENDED

I, John C. Molina, certify that:

1. I have reviewed the report on Form 10-K for the year ended December 31, 2003, of Molina Healthcare, Inc.;

2. Based on my knowledge, the report does not contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by the report;

3. Based on my knowledge, the financial statements, and other financial information included in the report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in the report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Rule 13a-15(e) and 15d-15(e) of the Securities Exchange Act of 1934, as amended), and internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) of the Securities Exchange Act of 1934, as amended), for the registrant and have:

   (a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;

   (b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

   (c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in the report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by the report based on such evaluation; and

   (d) Disclosed in the report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and to the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

   (a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report information; and

   (b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

/s/ JOHN C. MOLINA, J.D.

February 19, 2004

John C. Molina, J.D.
Executive Vice President, Financial Affairs,
Chief Financial Officer and Treasurer

EXHIBIT 32.1

CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the report of Molina Healthcare, Inc. (the "Company") on Form 10-K for the year ended December 31, 2003 (the "Report"), I, J. Mario Molina, M.D., Chief Executive Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

February 19, 2004

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

J. Mario Molina, M.D.
Chairman of the Board,
Chief Executive Officer and President

EXHIBIT 32.2

CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the report of Molina Healthcare, Inc. (the "Company") on Form 10-K for the period ended December 31, 2003 (the "Report"), I, John C. Molina, J.D., Chief Financial Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

February 19, 2004

/s/ JOHN C. MOLINA, J.D.

John C. Molina, J.D.
Executive Vice President, Financial Affairs
Chief Financial Officer and Treasurer